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BoggsCast Episode 43: Trauma, Grief, & the Power of Connection

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MELISSA CHEPLIC: Welcome to BoggsCast, where faculty and staff at The Boggs Center on Disability and Human Development explore best practice, showcase success stories, and help listeners envision possibilities for innovation through interviews with state and national experts. Part of Rutgers Robert Wood Johnson Medical School, The Boggs Center is New Jersey's University Center for Excellence in Developmental Disabilities and Leadership Education in Neurodevelopmental Disabilities program.

I'm Melissa Cheplic, Senior Training and Consultation Specialist. In this episode, we will be discussing trauma and grief for individuals and their staff in the dual-diagnosis world. Today, we welcome Lara Palay. She is a psychotherapist with nearly 30 years in private practice, specializing in trauma and loss, a co-founder of Aldridge Palay Consulting. Ms. Palay started her career as an hourly worker and went on to be a supervisor and clinical director for multiple mental health agencies.

Lara taught clinical social work at the Ohio State University College of Social Work MSW Program for over a decade. Ms. Palay served as the project manager for the Mental Illness and Developmental Disabilities Coordinating Center of Excellence for the State of Ohio, helping to advance trauma and mental health understanding dual diagnosis. Welcome, Lara. Thank you so much for joining us.

LARA PALAY: Thanks, Melissa. I am so excited to be here.

MELISSA CHEPLIC: So let's jump right in. Let's talk a little bit about what trauma looks like, especially in the dual diagnosis world. How does trauma typically present, maybe differently in individuals with dual diagnosis? And what do you think are some common signs that clinicians and care partners may misinterpret or overlook?

LARA PALAY: I'll give you the shorter version of what could be a super long answer. The shorter version is that when you talk about intellectual or developmental disabilities, you are talking about, as you know, such a wide spectrum. And so, on one end of that spectrum, you're going to see individuals who need very, very minor or very specific support in specific areas, but in other ways look very neurotypical in other areas of their life.

And so for people like that, I would say, trauma looks a lot like how it looks for anyone else. And then, of course, you've got like, way at the other end of that spectrum, where if people need a lot of support, if

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they have limited or no verbal speech, or if there's any other kind of language or communication barrier, that can be a little harder.

What I'm going to say maybe goes against what people would think, because usually what people are looking for is a list. If someone does A, B, or C, then this is what's going on. But trauma is a little tricky, even in the neurotypical world, because we tend to think about trauma in terms of the story or the event.

So if I'm talking with you, Melissa, and you tell me XYZ happened in my life, then I go, oh my gosh, I wonder if you have trauma from that? And that's an OK path of reasoning to be on. But the difficulty there is that you could take 10 people and have them all go through the same stressful event, and some of them might show indicators of some issues with post-traumatic stress after that event, and some won't, because we've got individual factors, we've got resilience, whatever.

So even in the neurotypical world, it's helpful to keep in mind that there's more than one direction that you can come at this from. One of those directions is, as I said, when you know someone has experienced stressors of early in life, repeated, or severe levels of stress, then you absolutely want to be screening for the potential for trauma.

But then there are other times where for whatever reason, you don't have that story or they haven't shared it, or they're not even necessarily thinking in those terms. And so then I look for things involving how activated or deactivated does their nervous system get. Look for those different activation patterns.

Is someone doing something that suggests to you that they're in that flight, fight, freeze, fawn zone? So does this person tend to-- and I'm going to use some very clinical language here for your listeners-- does this person freak out? Do they look like they're in fight-or-flight?

Do they talk about or demonstrate that they get very activated for safety, as we say, in trauma therapy? So they're looking for an exit or they're suddenly very combative or they get very placating-- are they demonstrating stuff that kind of looks like that? Well, then you're going to start asking some of those questions.

Or at the other end of that activation range, do they look really checked out? We used to call it, in one of the agencies where I started, we would call it, someone kind of took a little mental vacation. You can see it in someone's face. They check out. They're not there.

Trauma can look like somebody who's kind of depressed or kind of irritable or sort of passive or rigid in their habits or whatever. Trauma can look different things. Again, whether you're talking neurodiverse or neurotypical, we see people demonstrate things on various ranges of that scale of activation of the nervous system, and that might make you look more closely. I would start with that.

The next thing I would say is that the less someone is able to communicate verbally, the more you have to look at the body. And as you well know, diagnostic overshadowing means we tend to either say, oh,

well, Melissa's just doing that because she has XYZ syndrome. Well, no, there might be a medical issue going on.

We're already sort of primed to think about, how do we screen and rule out medical things? Like maybe Melissa's banging her head because her tooth is impacted or whatever. And I think we need to add trauma and mental illness, generally, to that mindset. Don't just assume that someone is doing what they're doing with their body or their behavior because they have some form of developmental disability. There may be something else going on, including trauma.

The last thing I'll say is that I started out working with teenagers. And when you are dealing with young people or children, there was a phrase I heard in the social work world that I think you've heard in the DD world, and that is "acting out." Our listeners won't believe this, but you just made the face that I make, that face of like, ugh.

But when I was supervising staff, I would always suggest to them that they put the word "it" in the middle of that phrase. They're "acting it out." In other words, if Melissa's being an enormous pain or freaking out or doing some stuff that I can't immediately understand, especially if communication has any kind of barrier, what if the way I look at that is that you are acting it out for me. You are showing me on the outside what it is feeling like on the inside.

And so I think that another way that we can have our antenna up for trauma is, is someone acting it out for you? Does their body look like someone who's scared or panicking or shut down and they're not in the room? So those are the places I start, in terms of what does trauma look like for someone with dual diagnosis.

MELISSA CHEPLIC: You bring up a really interesting point, which I think is helpful for our listeners, which is that it's not an investigation necessarily. We don't always know what has happened to people, maybe because they can't tell us or maybe because they haven't told us. But we're still going to see those activation patterns. And I love the framing of that because it's a tangible, observable thing that we can look for and our staff can look for.

But to your point, it looks a bunch of other things. Trauma does look like other mental health conditions, and trauma can look like being in pain. So what do you think, unfortunately, are some of the maybe mistakes or misinterpretations with behavior that we tend to see, particularly people that we support who have disabilities that could potentially make things worse if we don't know what we're looking at?

LARA PALAY: Oh, yeah. Well, the first thing I want to say is that we have to factor in time. The plus and the minus, I think, in our field is time. What I mean by that is that it is true that sometimes individuals can live with a story that's been told about them for many, many years or even decades until someone takes a second look and goes, gosh, maybe they're not just trying to make life difficult for other people. Let's take another look. And again, that applies to so many things beyond trauma, but certainly with trauma, that's something that we see. But the good side of time is that it's OK for staff or families or teams

to take time and look at things over time to go, gosh, I've noticed that whenever Lara walks in the room, Melissa seems to pull back into her body.

It looks like she's getting scared. You can put pieces together. And so I think the first thing I would say is, give yourselves time, but also communicate. One of the things that I've seen in the DD world so often, there's a team, whether you formally recognized it or not. There's a parent, there's a provider, there's staff, there's a nurse, there's a psychologist.

I think when you have people talking regularly, the individual themselves, of course, you can start putting some of those little tiny pieces together. But when we're not aware of what's going on with someone, we make a couple of assumptions that I think can be not great or potentially even retraumatizing. The first one, I think, is assuming intention.

We tend to think people do stuff on purpose or intentionally. So you meant to ignore me instead of you just didn't hear me, or you meant to bump into me instead of you just didn't see me. So it's this weird contradiction that human beings are prone to. And so I think one of the things we do is we don't often consider that there may be something going on that we don't know about.

Now, that could be a huge range of things. In the DD world, there could be a syndrome that someone's dealing with or a neurological issue that we're not aware of, which is why we need really close collaboration and frequent assessments and making sure people have lots of different people with different skill sets who get to be a part of this person's life, at least occasionally.

But we also need to give people a little grace. I'll give you an example. One of the things a lot of human beings do when they're scared is they become aggressive. Now, if I have a developmental disability, then that could look like anything from being a little snippy and hurting your feelings to throwing chairs at you.

MELISSA CHEPLIC: Absolutely, yeah.

LARA PALAY: Right? But that's also true of everyone else as well. We tend to assume that whatever they're doing is intentional and not a reaction to something. And I think when we do that, it immediately puts us into a defensive posture. I need to get you to stop that because that's not cool.

The other thing in the DD world that I think is really a double-edged sword is our expertise in behavioral assessment and behavioral intervention. And I will say right here, my disclaimer, I'm a psychodynamic therapist. My opportunity to be in the DD world this past 15 years or so, I've gained a lot of appreciation for the close observation of behavior that I've seen.

And it can be a really powerful tool, but it can create its own kind of tunnel vision like anything else. So if you are doing something-- and this is honestly where trauma often comes to people's attention-- is you are doing something that's making life difficult for other people.

If you, Melissa, are somebody who tends to, you just get shut down or you just get kind of quiet or you get very passive and compliant, that's not always going to come to the level of people's attention, as if I'm the person who's throwing chairs and throwing hands and stuff or running out the door.

The challenge with a field that has such expertise in looking at behavior is, not letting behavior be the beginning and the end of the story, that, OK, Melissa's doing this stuff and it's weird or it's difficult or it's dangerous or whatever, and so we're going to take a behavioral view of it. And then if we find a way to get her to stop doing it, problem solved.

The problem here is that on the one hand, I can probably get you to do what I want you to do, but it doesn't mean that I've helped you to stop being afraid of people or thinking that you are a bad person, or that you have to manipulate to get what you need.

All it's done is make you compliant with my expectations. That's not nothing, OK? That might be very important. That might be where we need to start, if you're running out into traffic. I get it, that's a great goal. But it doesn't heal anything. It's literally replacing a bandage on a wound that never heals.

The other problem is that it's very hard, I think, to see where the line is between intervening to help shape someone's behavior in a more pro-social or more functional way versus control. Human beings really like controlling other human beings.

MELISSA CHEPLIC: Absolutely, yes.

LARA PALAY: We just like it, I get it. And the truth is, especially in the DD world, I potentially have access to things that I can absolutely use to control you. Do you know what I mean?

MELISSA CHEPLIC: Yes. One of the interesting things that you're describing is, we are more likely to notice things that make caregiving harder. We're less likely to notice things like sleeping a lot, being withdrawn, flat affect, the typical clinical presentation that we would look for. In our DD world, in our systems world, we don't necessarily look for things. We become aware of things.

And behavior changes because people's needs have changed. Your needs are changing, your behavior's corresponding to that. So I appreciate what you're saying about thinking about it more broadly. Yes, of course, being able to see and measure the behavior is so important. But also, what are we not seeing or what are we not seeing right away? And knowing what to look for.

LARA PALAY: Yeah, and you just used a phrase that I'm 100% stealing. Are we looking or are we letting it emerge? And of course, it's a balance of both. And that's why I wanted to start with, sometimes this just takes time.

MELISSA CHEPLIC: Absolutely.

LARA PALAY: It takes time for enough people to go, gosh, is there something else? What pair of glasses you're wearing, I think really matters.

MELISSA CHEPLIC: I want to go back to something you said around all the little pieces, putting them together to really understand someone's entire experience. Part of the reason that we're having this conversation and elevating it is that these trauma experiences are so common for people who have disabilities, especially IDD, especially IDD with mental health.

And grief and loss, the grief and loss that comes across the life course at all different iterations of transition and people dying and relationships ending. And staff leave and turn over and medications change. And I wanted to ask you, what are these unique vulnerabilities? Why is grief and loss such an important piece of the trauma conversation when we talk about dual diagnosis?

LARA PALAY: Yes, I love that and I love framing it that way. I think grief and loss now is what trauma was 15 years ago. Or at least I hope that. Maybe that's just aspirational, that it's the next big thing we talk about. Because they're kind of like branches of a tree. They really do share a root, and that root is connection.

I want to go in another direction and talk about some of the other vulnerabilities to trauma specifically. But then we're going to come back and I'll talk about where those two things really come together. We know that people with any form of disability at all, physical disability, developmental disability, are more vulnerable to traumatic experiences simply because they're more vulnerable.

If you have a lot of different people in and out of your life-- and there are a lot of provider agencies out there that are trying their best and doing a great job, but there's high turnover. People are in and out. Well, the more people that are in and out, the easier it is for someone to get through the cracks who's not there for great reasons.

We know that people with any form of disability are more vulnerable to poverty. They're more vulnerable to living in areas where there's higher crime. We're already talking about a more vulnerable population. And especially as we start talking about developmental disabilities, if communication is more difficult, or if people just tend to not listen to you or not believe you, that leaves you more vulnerable to being exploited.

So in terms of what we call the big T traumas, like someone is physically or sexually or emotionally abusive to you, you are already in a position that makes you more vulnerable to that-- trafficking, exploitation, all of that, more vulnerable. But then let's talk about the little t form of trauma, which is that daily frustration, the daily devaluing, the daily communication barriers.

Honestly, I think about this all the time. The frustration or the stress of not easily being able to make yourself understood or people immediately dismissing what you have to say makes me nuts. Like, just thinking about it makes me want to have a panic attack.

There is so much stress, I think, that can go into simple daily life. And let's not forget people, let's say, who have sensory processing issues, being overwhelmed by what's happening in your body, which can absolutely send people into those survival ranges of hyperarousal or hypoarousal when your own nervous system is just bombarding you.

So we know that, statistically, people having exposure to potentially traumatizing levels of stress are upwards of 90%, higher than 90%. You need to be thinking about trauma as if everyone in this field has had at least exposure to potentially traumatizing levels of stress. So in terms of what is the vulnerability, then simply, statistically, that's how we can talk about that.

Vulnerability, emotionally-- and this is where I'm going to bring grief in-- I think you can really argue that trauma has some grief in it, and grief has some trauma in it, for a lot of the folks that we're talking about. Michael De Bellis has done a lot of writing in the past, and he also focuses largely on developmental trauma, trauma in childhood.

And he argues that the essential vehicle of trauma in childhood is damage to connection. And that could be, someone is doing something to a child, right? Or it could simply be the chaos in a child's life-- their caregivers are struggling, or they're back and forth between different caregivers, or they're in the foster system early, or something like that.

And I would argue that that goes on throughout the lifespan. So we know, for example, teenagers bullying or social isolation can be a tremendous source of trauma. And in adulthood, loss, there are some forms of loss that I see in my practice that are traumatizing, not because of the circumstances of the loss, but because of the loss itself, the loss of a partner or a child or someone really important has some traumatizing elements to it.

And so what makes people vulnerable to struggling with grief and loss in the DD world is often, loss goes unrecognized and losses undersupported. So to knit these together, I want to just talk about grief for a second. If you imagine your life, Melissa, like a spider web, or mine or the listeners, hopefully, we have a pretty robust spider web.

So if you picture that, there are a lot of strands and there are a lot of connections. And now I want you to imagine dropping a pebble through that spider web and stretched across something or whatever. And you drop a pebble through it. Well, it's going to make a hole and you can see it. But if it's a pretty sturdy spider web, you can repair that and then there's all this other web that's still there.

But now I want you to picture a spider web where there are only two or three strands, maybe four. And now drop that same pebble through it. It obliterates it. So if I'm an individual and I've got one staff person that I trust. I have a roommate that I'm really close to. I've lived at home with my mom and my dad all my life and then they pass away.

The issue there is not that grief is different for people with developmental disabilities. I don't believe that it is. I believe it's a primary, foundational human experience because connection is a primary human experience. As you know, the human brain develops the capacity for connection long before it develops its little front-brain, thinky-thought, executive function stuff.

Like, that stuff's great, but your brain and my brain, when we were developing in utero and in the first years of our life, our brain was much more concerned about our ability to connect with safe human beings. That's how our brains develop. And so when connection is threatened, all human beings respond with some form of pain. If you are someone who's only got a few connections in your life, then that is obliterating, devastating.

So why we need to be talking about trauma and grief and loss together is that they both relate to a threat to what makes us feel most safe. And for much of the human experience, what makes us feel safe is connection. And loss of connection also creates horrible pain. So I really feel like trauma and loss should be, in some ways, the same conversation.

MELISSA CHEPLIC: You talk about connection. And our goal, of course, is always, we want people to have relationships with people who are not paid to be in those relationships with them. This is what we want for all of us, whether we have a disability or not. But given what you described and what we know, that's not always the reality.

And people in service systems and people who get support, they often do rely on paid professionals to really provide that connection for them. And we know that our DSPs, our direct care staff, are so invaluable in supporting people through this loss and this grief. So how can professionals really build trusting relationships to make it safer, right? If we feel connected, we feel safe.

LARA PALAY: Yeah.

MELISSA CHEPLIC: So how can those who are paid to be with people really create that safety, especially if they're not able to articulate that they don't feel safe in this moment? What are some features of that trusting, connected relationship?

LARA PALAY: Yes, I agree 100% with everything you just said. There can be profound healing in the context of those safe relationships, and I think professionals have a huge role to play. The primary thing they can do, and this is a little counterintuitive, because I can talk all day long about what are the various ways that an individual can show you that they're scared or that they're hurting or that they're isolated. But where we really have to start is ourselves. So the first thing a staff person or family member, an employer, whoever we're talking about, the first thing they can do to build that safe relationship is to work on whatever helps them feel, as I talk about in Trauma Responsive Care, safe, connected, and in control. You can use other language. That's just a little thing I put together.

But whatever's going on, do you know how to recognize whatever feelings come up in you? I'm not at all saying that we all need to be some perfect picture of mental wellness to do our jobs well. But I do need to have some self-awareness and some self-regulating ability. So that's the first thing in terms of building that trust and safety is-- can I come into an interaction with some ability to recognize what's going on inside you?

When you feel pretty OK, or when you feel frustrated or whatever, do you have some strategies to work with that? Do you have people around you who can support you with that, or supervisors who are there to support you with that? There are various versions of this, but I put together a model called the Calmer Skills. And they aren't about individuals, they're about staff.

The Calmer Skills just take you through a very simple sequence-- it relates a lot to Daniel Siegel's work on mindful awareness, so people will recognize that-- of just recognizing where you are, what you're feeling. What is this bringing up in you if someone's being challenging or frustrating or that we're simply not feeling very helpful?

Staff usually, and family members especially, are driven to be helpful. So if you're working with me and you can't seem to help me not feel sad or scared, that can make you feel a certain kind of way, as the kids say. My children love it when I try to use current slang. So can you as a staff person allow for that, work with it, recognize it, and not let it control the interaction?

So often what I observed, both as a staff person and then as a supervisor, is that staff are having feelings they're not acknowledging, they're not working with. And so the first thing is staff need to come with some level. Again, it doesn't need to be perfect. You don't need to be the Dalai Lama, but some ability to recognize and work with what's going on inside.

The next thing is, someone used this phrase with me once and I loved it, are you a solid object? Are you going to be consistent with me? So if I'm the individual and you're my staff person, are your expectations for me pretty much the same day to day? Or do they depend on your mood or what kind of day you're having? And again, it doesn't need to be perfect, but it needs to be consistent.

And then thirdly, can you tolerate where I am? So if I'm having a tough day, can you make space for that with me and still want to be there with me? Do I need to earn connection with you? There's so much we can communicate to people, often very subtly, about, I like what you're doing or I don't like it.

Your feeling is acceptable to me or it's not. Let me give you an easy example. If I'm crying and you say, oh no, no, no, don't cry, don't cry, that's a very human response, I get it. But what are you, Melissa, communicating to me when you do that?

This is something we struggle with when talking about grief and loss all the time. Lara's grandmother died. If she starts talking about it, she'll get sad and she'll cry. So redirect her. I would see that in 100 treatment plans or behavior support plans or whatever.

MELISSA CHEPLIC: Absolutely, yes.

LARA PALAY: Right? And so again, an individual person with a specific team with a specific plan, there may be a place for that. But so often what we're really saying is, it bums everyone out when Lara is sad and we can't fix it. So many of us are in this field because we are empathetic. And this is verging off into my next project, which is about staff burnout and staff trauma.

And empathy is very much a dangerous gift. Because you, as an empathetic staff person, are able to feel when I'm scared and you may be able to reassure me. And so, going back to the first part of your question, one of the ways you facilitate my safety is because you can tell, because you can empathize with it.

The downside of that, or the other side of that, is that if I'm feeling something and it's uncomfortable for you, or it triggers your stuff, or you think your job is to help me not have a hard feeling, and I keep having the feeling and it's not going away, then you can communicate in many, many different ways, very directly or very subtly, that I shouldn't be having that feeling and you would like it to stop, please.

So we have people with trauma who never get to work through-- I'm scared with you. Can you help me feel safe with you? You're just trying to shut it down, as my staff person. Or I feel sad because I have this grief and you are trying to get me away from it, rather than feeling it and recognizing it and helping me to heal it as a human.

There are 100,000 different ways right now in our country that staff people are helping a specific person feel safe that is unique to that person. The universal of it is, you have to be a safe place.

MELISSA CHEPLIC: There are 100,000 potentially different things and many of them are good. And to your point about redirect, that's the next piece. What are we directing to?

LARA PALAY: Yes.

MELISSA CHEPLIC: How are we redirecting? And really getting to know people and what makes them feel safe and connected, that's the rest of that conversation. That's the rest of the directive. Redirect, on its own, kind of sounds like the end of the sentence. But if we start to know people and what makes them feel comfortable, we can talk about those safety things to redirect them to.

But it's hard to be a solid object if you, yourself, are feeling unsafe. And so many of our staff, so many of our direct support professionals, as you mentioned, parents and caretakers and care partners and family members, also have complex trauma histories. In this context of caring for people with trauma, how does vicarious trauma look different from the typical burnout that one gets in this field, or are they different at all?

LARA PALAY: Well, I would say that burnout is the umbrella, and vicarious trauma is absolutely under that umbrella. There are other factors that contribute to burnout as well. To that point, briefly, I want to go back to something that you talked about in terms of safety. All too often, family members or staff people are in situations where they are literally not safe.

Before we talk about emotional safety, we always need to identify if there's a parent or a staff person who's being asked to do something that is quite literally unsafe. Now, to go to the next part of that, though, in terms of emotional safety, there are again, a couple of different pieces to that. One is, we are all humans. And humans have their own history.

And I know you said you started as a DSP. Let's look at that population for a second, that workforce. We know that a lot of folks in the DSP world or the provider world are also family members who are supporting an individual. That may be how they came into the field, to be a staff person, as they have a family member at home that they're caring for.

Or they are grappling with their own stressors in terms of insufficient income or where they're living or the relationships they go home to at the end of the day. So there is an amount of trauma that individuals or people in the workforce may be dealing with just because it's part of their lives. So that's the first part.

The second part, when we talk about vicarious trauma or secondary traumatic stress, is where we get into trauma that comes from the work that you're doing. That can happen a couple of different ways as well. If someone has put you in physical danger at your workplace or harmed you, that can be traumatizing. But the version that you and I are talking about today really comes from empathy is that root place, that beautiful, dangerous gift.

And NADD is publishing my second book about this topic. And now I'm thinking "A Beautiful, Dangerous Gift" would have been a great title, but it's too late. So, so many of us in the helping professions, in this case, dual diagnosis, are drawn to it because we are empathetic and we are good at figuring out where someone else is and helping them where they are.

But if you think about what that really means, empathy, at least emotional empathy, means I'm feeling what you're feeling, to some degree. So if you're my staff person and I'm feeling A-OK and you're connecting with that, you're feeling some part of that in your body. And you're like, oh, Lara feels good, I feel good, great. Then empathy is a really fun thing for you to have.

If I am dysregulated, I am freaking out, I am terrified, I'm enraged, I am shut down and numb and checked out, and you are emotionally empathizing with that and reflecting that in your nervous system, to some extent, which is what empathy is on that level, that doesn't feel so good. Your nervous system is experiencing some of those same things, the agitation, the fear, the anger, the whatever.

So what we see over time is, especially when you don't know that's what's going on-- I talk about this actually in my book. As a trauma therapist, when I walk in my office, I know I'm going to sit down with

somebody who may be in some of those activated states, and I can go, [BREATHES DEEPLY] OK, and get ready for that.

If you're my staff person and we're just, I don't know, making dinner together and I'm suddenly dysregulated and you have no idea why-- maybe I have no idea why. Maybe you don't know any context or narrative to put this in. Then, it can take a toll on your nervous system as my staff person.

So when we talk about safety and trauma for the workforce-- again, family members, supervisors, the whole tribe of people around an individual-- that's how we can start to see symptoms of PTSD in people in the helping professions, simply by being close to people who are struggling with it.

This is what this next book is all about, is shifting our brain states and shifting our nervous systems so that we can be present and we can witness those feelings, and we can support those feelings, but we're not sucking them into our bodies and our own nervous systems at the same time.

MELISSA CHEPLIC: We have a responsibility to those who are closest to the work to acknowledge that this is happening, while they're providing this everyday safety and connection to people who need it. How do you think that agency leadership, provider leadership can really model the trauma-informed care that we expect them to provide to the people that they're supporting? How can they really model and set that expectation of compassion and safety and connection for the workforce?

LARA PALAY: Well, the first thing I will say is, as providers, as supervisors, we can be treating the staff that we support in the same way that we want our staff to be treating the individuals that they support. In other words, we want them to feel safe, connected, and in control.

We talk about individuals have such a high rate of trauma that you should treat it as a universal precaution, treat everybody, every individual you're working with at any given moment, whether they're demonstrating something or they've been diagnosed with trauma or not, as if they need to feel safe and in control of their choices and connected with a safe human being in their presence all the time, before we ask them to do anything else.

And I would argue, an agency that wants to embody that for their individuals, let's say, needs to be practicing that throughout the agency. So now I'm your supervisor and we're talking. What am I doing? Again, maybe starting with me. How am I not letting my emotions, my stress, my trauma, whatever it is, how can I stay grounded and present with you and support you, even if I do need to be doing some disciplinary action?

Can I try to make sure that emotionally and as a human being you feel safe and respected in my presence? Then you're more equipped to go out and have that safe, respectful presence with the individual that I want you to be working with. Recognizing that DSPs are grappling with some of the same things our individuals are, some of our DSPs are working below the poverty line.

They are grappling with issues in their life. Are we making sure that if, I'm your supervisor-- and, of course, you need to maintain professional boundaries and all of that-- but how can I help you to be taking care of your life in whatever capacity is appropriate, and valuing your well-being as much as I want you to value the well-being of the individual that I'm asking you to serve?

MELISSA CHEPLIC: Absolutely. We have to help the helpers. In real ways, adopt those attitudes, those habits, those practices, organizationally, to be able to provide that support to our workforce. Lara, this has been such a wonderful conversation. We're so grateful to you for your time. Before we wrap up, is there any final thought you want to leave our listeners with?

LARA PALAY: I say this a lot in trainings or in various places where I get the wonderful opportunity to chat with people. I, by my nature, by my training, by my work, look for the places where human beings share. Humanity-- what is it that makes us human? Feeling scared, feeling hurt, feeling pain, that's trauma and grief.

And so I'm often talking about those universal human connectors, those things we all share as human beings. And I want to be sure that I balance that with, there are things about having a developmental disability or dual diagnosis that are also unique. So in no way do I want to say, oh, we're all the same, just treat everybody the same. That's not true. We need specialists.

We need people who have that very, very specialized knowledge of medication or behavioral supports or this particular form of intervention or this particular syndrome or whatever. So I always want to make sure I balance, we need expertise. We need the specifics of the autism spectrum or this or that element of having a developmental disability or mental illness, but we also need that human foundation.

And so I feel like whether it's the world of dual diagnosis and what The Boggs Center does, or other places around the country where those conversations come together, where we take the narrow end of the funnel, the specifics of this particular diagnosis or this particular population and that compassion and understanding of what it's like to be a human being universally, I think they need to always be part of the same conversation.

So I want to acknowledge that. I want to celebrate that. I want to thank you. And what The Boggs Center and places like you guys do. And thank you for giving me this time with you. It was super fun.

MELISSA CHEPLIC: Well, thank you so much for all the wonderful thoughts you shared with our listeners. And always, of course, Lara, helping us close out on a positive note, so thank you. Thanks for listening to this episode of BoggsCast, a podcast by The Boggs Center on Disability and Human Development. A full transcript of this episode can be found at theboggscenter.podbean.com.

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