West Yorkshire
Violence
Reduction Unit

West Yorkshire
Health and Care Partnership

Trauma informed language Guidance

Authored by:

Lisa Cherry, Director, Trauma Informed Consultancy Services Ltd.
MA, DPhil Researcher, University of Oxford.

Contents

"Language as a tool of power or language as a powerful tool"

Guidance Findings 2023

How to use this document

This document is to be considered as guidance which supports conversations about language across all services in West Yorkshire. It is not exhaustive by any means. It is a tool, a thinking place, an opened door into moving towards trauma informed settings, services and systems. It is an invitation to develop deeper awareness around stigmatisation, understanding that when we change the language, we change how we see the world.

Some space and time is required to read this document which can also be used in supervision, team meetings and there will be training and eLearning available to support this document coming soon. Your commitment to the vision as outlined below, is what makes West Yorkshire! Thank you for all you do and all you about to do.

Introduction

"Oppressive language does more than represent violence; it is violence; does more than represent the limits of knowledge; it limits knowledge."

Toni Morrison (1993)

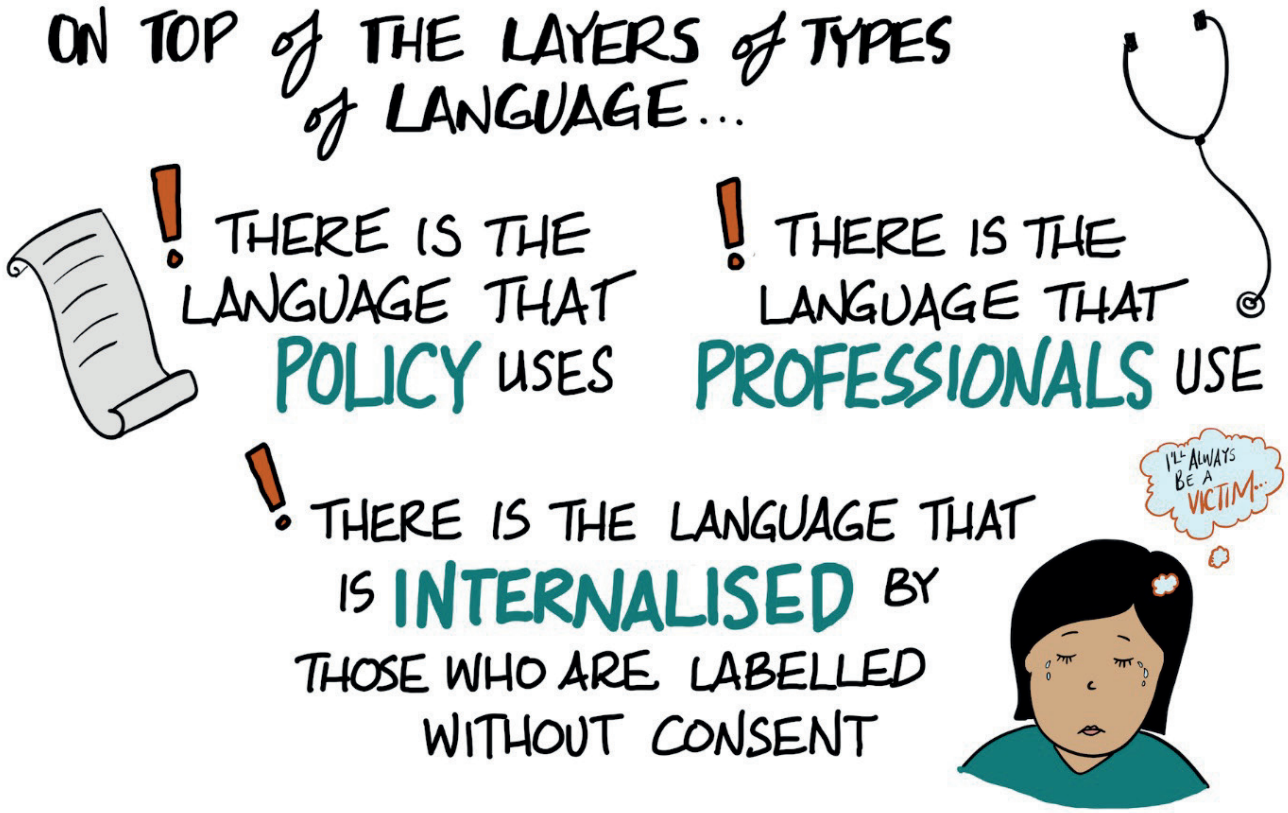
The language used across all our services is arguably drenched in stigma, judgment and without regular reflection, problematises the individual. While this is especially prevalent in mental health services and the criminal justice system, it is also a huge component of children's services and within education. The central means by which we can meet our aims and objectives is through building trusting relationships, and communication is the manifestation - the making real - of those relationships.

However fleeting and however transactionary those relationships are, they are all defined by language. It is essential that we understand how language, left unchecked, can enforce, re-enforce and also create and add to additional power dynamics that are very much at odds with working with a trauma informed lens. In other words language matters; what we say and how we say it matters.

Not everyone will agree collectively about how we think about language used in settings, services and systems. As such, writing a guidance document on language is incredibly challenging. It is a multi-layered area and fuelled by complexity. Yet, awareness on the language we use and the impact that this can have in how we work together is profound. When we change the language we use, we change the way we look at what is in front of us. For example, are we looking at 18% of children between 7 and 16 years had a probable mental disorder OR are we looking at 18% of children who struggle to thrive in our inequitable and unequal society? Are we working with someone who is 'hard to reach' or are the services they need to help them 'hard to reach'?

Interpersonal communication occurs through forms of language. Whether it is written, verbal, sign or body language, every interaction between individuals conveys implicit and **explicit** messages. Explicit messages can be written or verbal, direct and obvious, words that communicate a specific message. **Implicit** messages, on the other hand, are indirect, underlying, and are reflected by our entire physical being. One's posture, facial expressions, tone of voice and choice of words, all convey one's underlying attitudes, beliefs, expectations about the other. When explicit and implicit messages are aligned during an interaction, there is an **authentic exchange of communication** between two people. When they are not aligned, words can convey one meaning but body language may convey another.

1 https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2022-follow-up-to-the-2017-survey



For service providers, whose role is to interact, support, advocate and defend individuals that seek services for their personal matters, language is the most powerful tool used to direct a positive interaction and outcome. The best outcomes materialise when one's implicit and explicit communication is aligned and authentic. This occurs when the individual perceives the meaning intended by the service provider. Authentic communication builds trust and positive relationships between the person receiving the service and the individual providing it. When the words, actions, attitudes and body language of the provider conveys mixed messages for the person using the service, it creates confusion, ambiguity and lack of trust in providers.
In order that this guidance could be written, The Language Task and Finish Group for the West Yorkshire Health and Care Partnership (WY HCP) Adversity, Trauma and Resilience (ATR) project held five focus groups. These focus groups were designed and co-created to explore how individuals experience language in their interactions with healthcare and mental health care providers, housing services, youth services, police officers and others. The co-production of this document reveals how language can harm, help, heal, threaten or empower the people who service providers serve. More importantly, it stresses the importance of training every individual working with the public in a trauma informed approach, developing the understanding that vulnerability needs locating in structural inequality and inequity, the availability of a variety of supportive services and access to high quality relationships and belonging. Furthermore, the importance of understanding the role of language and how that creates systemic and cultural changes to one that is more trauma informed, is central.

Vision

Adversity trauma and resilience vision for West Yorkshire Health and Care Partnership (WY HCP) and West Yorkshire Violence Reduction Unit (WY VRU)

Our ambition is to ensure West Yorkshire is a trauma informed and responsive system by 2030.

To deliver our agreed ambition the approach is for all organisations and system leaders to work together as trauma and adversity cannot be prevented and responded to by one sector.

We want to:

- Prevent adversity and trauma across the life course
- Respond to trauma and adversity that already exists, mitigating harm where possible
- Facilitate an integrated trauma informed and responsive system that enables all people, including those with complex needs to thrive
- Build and strengthen resilience assets and protective factors for individuals and communities
- Reduce risks and improve outcomes for those who experience adversity and trauma
- Ensure people can develop meaningful relationships with experienced professionals, who will champion on their behalf placing them at the centre of care, coordinating services around the child & family
- Provide senior clinical leadership across the system, strategic oversight, embedded reflective practice, specialist input and psychosocial interventions
- Reduce inequalities that contribute to adversity and trauma and inequalities caused by adversity and trauma
- Ensure an understanding of adversity and traumatic events and the impact they have on an individual, their life chances and opportunities
- Develop our response to adversity, trauma, and complex needs in this window of opportunity to build back better and fairer and minimise harm caused by COVID -19 and associated measures

Underpinning this work is the principle that the voice of our population and communities is at the heart of everything we do.

Aims and objectives

The purpose of this document is to think about language using a trauma informed lens. In applying this lens, a number of areas are raised that need consideration. This guidance has been co-produced, evidenced by gathering lived and living experiences using focus groups around the West Yorkshire Partnership region and has been underpinned by research sitting within the framework of the trauma informed principles. Incorporating reflection around language and then changing it, is not as easy to do as we would hope.

We have adapted and shaped our thinking throughout our own lives via our own relationships and experiences in a society that stigmatises and individualises poverty, addiction, homelessness, prison, school exclusion, to name a few. Alongside this, our chosen professions are full of acronyms, power dynamics and judgements. Our society is more visibly divided and judgemental than ever before. This is explored further in the section on positionality. However, with some reflection, some curiosity and some humility, we can learn to do better.

We are not seeking perfection but we are making a commitment to listen, to apologise when we get it wrong and to adjust what needs adjusting. Having a focus on language brings a number of benefits leading to the co-creation of new ways to phrase things that are more meaningful, inclusive, respectful and engaging and that do not perpetuate self-stigmatisation which has internalised external stigma.

Trauma informed principles

The guiding principles of a trauma informed framework are:

- Safety
- Trustworthiness and transparency
- Peer support
- Collaboration and empowerment
- Empowerment, voice and choice
- Cultural humility

and it is these principles that underpin all aspects of this document.

The guidance will be primarily concerned with:

- Language that harms
- Language that heals
- Understanding body language
- Language as power

Aim

- Seek to ensure that the guiding principles of a trauma informed framework underpin a continuous reflection about language and its impact on those using services across the system
- Provide guidance that can be used across any sector, system or service which can be adapted accordingly
- Ensure that curiosity, humility and belonging are centralised into collective thinking about language

Objectives

- The guidance will ultimately seek to move towards a common language and a common way of negotiating language
- The guidance will provide a reflective, thoughtful and critical opportunity for all to consider Trauma Informed wisdom that particularly centralises safety, cultural humility and voice, choice and empowerment

Wisdom gathering

This section explains the process of gathering wisdom around language and was informed by the Trauma Informed Co-Production Guidance.

Methods

The following questions were guiding, open-ended questions for the facilitator of the focus group to ask. They were designed to invite prompts to further questions, to open up discussion and to be flexible to different interpretations and understanding around language. The questions were asked in such a way as to open up ideas for other questions to be explored that were specific to the community, setting, service and/or system.

The focus group guiding questions were:

1. What does it mean to you to think about the word 'language'?
2. Can you share any experiences, positive or negative, you've had that are connected to 'language'?
3. What changes would you like to see happen around some of your thoughts, ideas and experiences around 'language'?

These are the questions with suggested prompts:

1. What comes to your mind when you think about the word language? Are there different forms of language? (Looking for spoken, written, body, signs) Are there different ways that language is communicated? (Prompt feelings, understanding, tone (warm, aggressive), body language (facial expressions) cultural competency / exclusive / inclusive (race and ethnicity, gender, sexual orientation, socioeconomic status, education)
2. What was it about the language used that you found positive/negative? Link back to the areas discussed in the first question. How did the language make you feel? (For example, safe, judged). Is it the spoken/written language or the way it is said? (body language / tone)
3. Link back to the settings. What would they like to see change? For example, written notes in medical files / school reports - what language would they like to see / be removed?

Findings

Analysis of the wisdom shared in the focus groups found 7 key insights (KI) which are further explored below.

KI 1 - Language as a form of direct verbal communication

Language as a form of verbal communication is the primary tool of dialogue between service providers and people seeking support for their services. Dialogue may consist of instructions, directives, actions that must be taken. It may be exploratory, to understand a person's need. Regardless of the context, choice of words, tone of voice, level of vocabulary conveys what type of relationship is being established with each interaction. Whether a brief interaction or lengthy exchange, the quality of the interaction is particularly important for the person seeking a service. Processes can be overwhelming for people and therefore knowing an authority is an advocate can only be conveyed through the quality of the dialogue and the relationship built, yes, even briefly. Every exchange is relational!

Language that is vague, for example saying "might", "could," can create confusion and ambiguity. Language that is defensive, hostile or emotionally charged, for example stating "I already told you that" or "If you don't do (this) then (this) will happen" creates fear and intimidation; it can trigger traumas and deter people from seeking help again. Humour can be perceived as sarcasm, especially when it refers to a person's current situation. Excessive formality maintains power status. For example, using complex, technical language and jargon or language that is generic, mechanical, robotic or child-like language by providers is undermining, creates distance in the communication and creates a feeling of being faceless, nameless and invisible which is exclusionary.

The wisdom gained from the focus groups indicates that language used by providers and professionals encourages approach- avoidance behaviours by the person that can either help or harm them. The person will either feel encouraged to seek future support or be "put off" and avoid seeking support from services. This can be detrimental in matters of physical or mental health, in meeting important deadlines, in legal matters and others. Language that "explains" and creates a shared understanding aligns the person-provider relationship and as a result, the purpose of the communication is fulfilled. The person receives the support they came for.

KI 2 - Language as indirect non-verbal communication

Language as a form of non-verbal communication or body language is a visual way that we detect safety known as neuroception as identified in Polyvagal Theory (Porges, 2004). Neuroception is how neural circuits distinguish whether situations or people are safe, dangerous, or life threatening. This process of finding safety in our interactions and environments communicates intention alongside underlying attitudes, beliefs, expectations about the other. This includes posture, hand gestures, eye contact, facial expressions, touch, physical space

between people, tone of voice and choice of words. Body language is instinctive. Verbal language is intentional. People understand when verbal language and body language are incongruent or not aligned. Neuroception argues that until safety has been detected, social engagement cannot happen.

Body language can strengthen the verbal message given, for example, a warm smile and direct eye contact enforce what is being said verbally. However, a pat on the back, being distracted, lowered eyes, raised eyebrow, tilted head, for example, contradict what is being said (Collins, 2022). Body language that conveys negative emotions or attitude disrupts positive communication with the other. Behaviours such as fidgeting with phone or object, addressing interruptions by others, constantly gazing at the time, make people feel rushed, ignored, and unimportant in the brief time they have come in for a service.

The wisdom gained from the focus groups indicates that an empathetic voice, focused attention and open and aligned body language conveys the message that, "I am here to listen, understand and address your issue with my full attention." It relieves the person seeking support from any hesitation, worry or negative expectations they had about coming in to receive the service. It creates psychological safety and invites fruitful dialogue.

KI 3 - Language as a system of writing

Service providers engage in writing a plethora of letters, emails, leaflets, manuals, policies all of which convey information to others. When writing for those who seek or engage in services, writing becomes a critical tool to provide vital information, procedures, processes and instructions to support a need. Taking into consideration the diverse number of people provided for and their equally diverse backgrounds, abilities and education levels, writing "for all" can be a challenge. It is important to seek a middle ground in levels of writing that can satisfy people that may have an expansive vocabulary to those whose English skills are minimal and need support or translating. This is also an opportunity to consider how 'hard to reach' your service might be in this area. Having access and support to communicate non-lexically, communication that sits between sound and speech is also relevant for this section, although this won't be explored in any detail.

Focus group findings suggested that written communication in letters, emails and leaflets need to be brief, succinct and personal. Addressing people by name was raised as important and infers that the particular communication is intended for a request or need that the specific individual must attend to. Bullet-pointing important items is more effective than lengthy paragraphs. Numerical sequences are helpful for steps that must be taken in a particular order. Simplifying contracts, that can often be jargon laden and technical, is practical. Clarity is most important. Excessive use of bureaucratic jargon creates anger, frustration, confusion and is exclusionary. Simplifying language in rules, regulations, legal documents and contracts is an inclusive practice that is necessary.

Being inclusive in written communication also means providing visual aids for those whose visual skills are more refined than their written skills. This might include the use of emoji's, icons, progress charts or photos of people from diverse backgrounds. It is also important to consider that not all people have access to computers and email accounts. Therefore email communication is not accessible for all people living precariously who do not have access to a computer

or electronic device. Communicating via telephone or in-person is a more effective way of reaching individuals in this situation.

The wisdom gained from the focus groups suggests that clear and uncomplicated communication invites ownership, partnership, and shared responsibility between the person and the service provider. After all, services are just that– they exist to support the needs of recipients; reaching them, connecting with them and engaging them in a shared partnership to address and facilitate the service needed, is the goal for all. Written communication can invite or dismiss those in need of the particular service.

KI 4 - Language as an indicator of listening

Language as an indicator of listening refers to both verbal and body language that conveys to the client that the service provider is paying close attention to understand their need. One of the most common examples cited by focus group participants was the need to be "listened to" and not only "talked to" when interacting with their service providers and practitioners. This suggests that clients often feel that the message they are trying to communicate is sometimes misinterpreted by providers. When they try to clarify, they are sometimes interrupted by the provider, as they too are trying to get their point across. Listening to respond rather than to understand can make a person feel ignored, unimportant, misunderstood and part of a process without an identity.

Ask, clarify, verify, acknowledge. Active listening is a skill that helps people feel understood. It involves paying attention, listening to understand, acknowledging, paraphrasing when interpreting, clarifying, asking questions. Using appropriate body language such as leaning forward, having eye contact, nodding, with facial expressions that show interest, are all the ways that help a person feel heard, paid attention to, validated and understood.

The wisdom from the focus group suggests that the quality of listening, attitude, language and comfort of an environment reflects the duty of care (or lack of it) communicated by providers. Therefore, listening intently before speaking or responding guides purposeful words and actions. Providers must be attentive and aware of the emotional state of clients to listen to understand, reassure, clarify and verify, acknowledge and diffuse rather than infuse and escalate.

KI 5 - Language as labels

Work environments often use codes and labels to categorize and use a common language. When these are used to refer to people and their conditions this can be problematic when expressed inappropriately. People are sensitive to language and labels that belittle, minimise, trivialise, target and judge another. Labels, for example, such as attention seeking, manipulative, needy, childish, inadequate, too dependent, too sensitive, non-compliant, to name a few are judgmental. Mental health labels are especially damaging as they often define a person by their condition without seeing the whole person. A person is not bipolar, OCD or histrionic, for example. They may suffer from these conditions, but conditions do not fully define a person. When a person hears discussions between providers, reads notes or forms that label them, it can be devastating. As one participant stated: "I felt very afraid of that title. It filled me with tremendous anxiety. I felt like a leper, a weakling bird, as I was called. I felt not human, a rat in a sewer,

the dirt under someone's shoe, a burden, a defective human being, inadequate, as they called me, scorned, humiliated, hated, despised, a freak."

The use of language to casually refer to people or view people by their physical, mental or cognitive ability is also known as "ableism". Whether done intentionally or unintentionally, ableism is a form of discrimination or prejudice against people with a particular condition or disability that is perceived as derogatory (Dunn, 2021). Statements used casually such as, "he's psycho," "what an idiot," "she's a nutcase," are ableist. Although it is not expected that professionals use this language to describe their patients, how people are viewed and spoken to in diverse service sectors can reflect a form of ableism that attacks one's self worth, insults, traumatises and excludes.

The wisdom from the focus group suggests that, particularly in mental health settings, "it's not just the wording of the language it's [also] the attitude and the long-held beliefs of looking at behaviour and not addressing the trauma. Not seeing the full picture of someone's life and experiences, like looking at a jigsaw with a lot of pieces missing." Effective mental health support must go beyond the use of a technique or orientation to treat a behaviour, it must utilise a trauma informed approach to reach the deeper layers of trauma to understand the whole person. Effective communication by providers means seeing beyond the label and addressing each person with empathy, sensitivity and dignity.

KI 6 - Language as a tool of power

Being in a position of authority automatically places a provider in a position of power over those they serve. The language that is used can either equalise one's power position or perpetuate it. It can align and defuse a difficult interaction or threaten and intimidate. Participants of this focus group had experienced the following statements: take responsibility; grow up; you're not mentally ill; you're not ill enough; compared to other people, your problems are minor; you are either bad or mad; compared to physically ill patients, what have you got to be depressed about? We all get depressed, there are people far worse off than you.

Power is also exerted when people feel they are being pressured to talk, not listened to, listened to but not heard, written about not written with, observed like being in a goldfish bowl, having no power of choice when seeking a male or female therapist. Law enforcement and others in positions of power have an enormous responsibility to be mindful of language as it can create feelings of fear, harassment and persecution by people that are in need of safety and security. Using violence and abuse of power intimidates. It is a missed opportunity to create a climate of cooperation and social integration. These are all examples of how language creates barriers to seeking and accessing services, as people will avoid places and situations where they feel intimidated, threatened and powerless.

Adopting trauma informed language can align the practitioner with the client and create a safe space with mutual trust for authentic dialogue as equals in a relationship with a common goal to achieve the purpose of the intended exchange. Language that strives for power distance sustains power positions. Language that strives for a relationship aims to minimise power the distance to achieve equity.

KI 7 - Language as a trauma informed powerful tool

Language that empowers is trauma informed. Language as a powerful tool and not a tool of power, can create an environment of safety, care and trust that can strengthen the practitioner/person using the service, alliance. It is this alliance that provides the support for a person to follow through on the services they seek. Whether it is taking care of their physical or mental health, providing the right care for their child, managing their finances – trauma informed practices embrace people and their needs and holds space for them. This space may be time for clients to understand complex information. It may be enabling their courage to speak up, to identify what they need, to envision their next step or simply, to express what is feasible for them to do or not to do.

Trauma informed dialogue is inclusive. It reflects awareness and sensitivity to age, gender, race, sexual and gender identity, religion, culture, but also physical, psychological and intellectual ability. Service providers must ensure that visual and hearing impaired persons can communicate with a provider. It requires translators so that people can express themselves and be understood in their native tongue. Translators also must be trained in trauma informed dialogue and know how to handle sensitive conversations as they mediate between languages, cultures and differing societal 'norms'. Being culturally aligned, builds rapport, trust, understanding and sense of belonging with the client.

Trauma informed dialogue engages the other in a relationship and a shared journey. This inclusive journey begins with an inquiry about the client's needs, acknowledgement and validation of their concern and a partnership in co-creating a sustainable solution, action or outcome. This is in contrast to the "expert" delegating to the person using the service from a hierarchical position but rather from a horizontal one, as equals in the process of making decisions about one's own life.

Trauma informed dialogue

In this section some examples are provided that may be helpful and may stimulate reflection. All these examples are made in direct response to the wisdom found in the focus groups.

Verbal communication (in-person and telephone calls)

1) Hello! My name is _____. What is your name?
2) What issue can I help you with today, person's name (for example, Mary)?
3) Mary, how is this issue affecting you?
4) What are your concerns or worries about this issue, Mary?
5) What have you done about it? What was the outcome?
6) Is there anything else I need to know to fully understand your issue?
7) Mary, what would you like for me to do to address/solve/support you/ on this issue?
8) This is what I will be able to do; I will not be able to do the following because (reason)
9) Let's figure this out together.

Asking questions to understand

1) I hear that ……
2) Have I understood correctly that ……?
3) Tell me if I have understood you. I understand that ……

Validating person

1) I understand you……
2) I hear that you are angry/sad/upset/worried/frustrated etc..
3) I can see how difficult this has been for you
4) You have been so patient/brave/strong… (validate how they have endured their situation)
5) I will do everything possible to support you/ address your issue/ (whatever client has asked for)
6) This is a complex issue, and I am not certain of the outcome, however, I will do everything that I can to find out/solve it

Trauma informed dialogue

Tone of voice/ style of language

1) Speak slow and clear
2) Use calm, friendly voice
3) Speak with warmth and care, as you would to someone you know
4) Reflect empathetic tone, even if client is expressing their frustration (it's not personal!)
5) Be reassuring
6) Avoid getting defensive when you hear a response you don't like. Rather, probe more about it. Validate and acknowledge their concern/frustration. Explain, offer an alternate view.

Neutralise assumptions and expectations

1. Treat everyone as an equal. Would your words, tone, body language be different if you were speaking with the Queen? Speak to everyone as if they were!
2. Use moderate vocabulary
3. Avoid child-like speech, as if the person can't understand.
4. Avoid complex jargon
5. You are the one that has the information that the person seeking support needs. Therefore, treat everyone as if they have the capacity to manage/overcome/solve issue with your support.

Non-verbal communication

Body language

1) Smile!
2) Make direct eye contact if you are comfortable to do so while also acknowledging that neurodiversity can make direct eye contact difficult due to it being overstimulating
3) Be attentive- avoid distractions, answering phones and interactions with other colleagues
4) Actively listen / ask clarifying questions to show you have understood correctly
5) Lean forward slightly when sitting or standing while speaking to the person
6) Be conscious of your facial expressions
7) Reflect what is known as unconditional positive regard (Rogers, 1957), even in difficult interactions

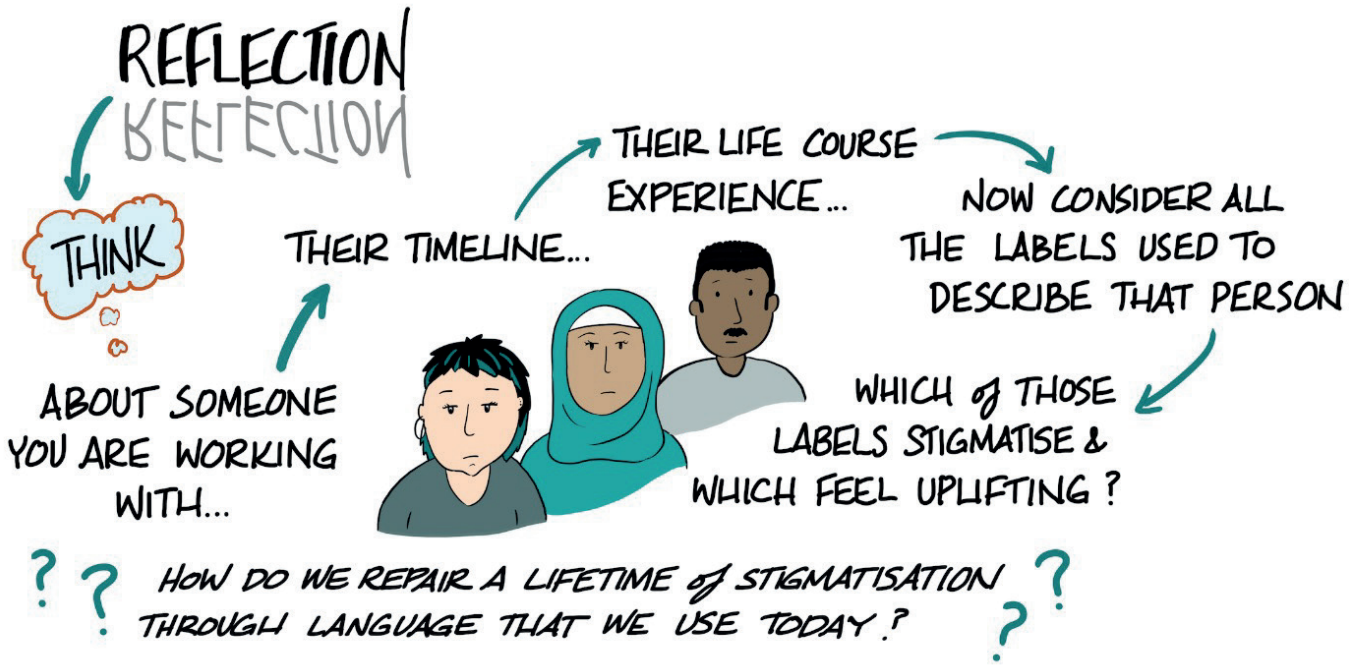
Written communication (letters, emails, leaflets)

1) Address person by their first name OR
2) Address person using Mr or Ms. and their last name
3) Avoid using Sir or Madam as it makes communication less personal and generic
4) Write briefly, to the point, with essential information only.
5) Use bullet points or short lists to convey lengthy details.
6) Use numbers for sequenced actions that client must take on a matter.
7) Use visual aids such as emojis, icons, progress charts
8) Verify if they have access to email or postal mail

Positionality

In understanding that there is language used within our society that is stigmatising and that there is language used in professional spaces that is infused with inequity and a fundamental imbalance of power, we are encouraged to think about the power that we hold and how that shows up. There must be consideration given to the ways that power can be shared and redistributed in the process of language. Thinking about our own positionality helps us to think about what privileges and what disadvantages we also have and develop a more reflective approach to understanding stigma, marginalisation and further our role in actively ensuring that those groups are not further marginalised and that there is action to reduce marginalisation.

Services and systems with their jargon and their acronyms have a tendency to reduce a person's experience to that of 'other' which by definition removes the complexity of a life lived. We are never one thing. We are many things to different people and we have had many experiences and relationships that we have adapted within.
Demonstrating an understanding of our positionality and the skills of reflection are an essential part of how we might champion good practice around trauma informed ways of working, ways of feeling and ways of being. Understanding where an organisation or a person is on their journey is a helpful starting point. Becoming trauma informed is part of a spectrum of movement that will shift and change depending on who is working in the system, how much energy and focus is placed upon it and how supported the people who work in that organisation are with their own experiences of trauma.



Staff support

As champions of this approach, advocating for practice that does not add to harm and mitigates effects of where harm has already taken place, it is important that we support, where we can, developing a more trauma informed approach to the language we use. Part of that is about the understanding that we too are humans, bringing our own life experiences, adversarial growth and potentially our own unprocessed embodied trauma that has yet to surface for processing.

Working within a trauma informed framework brings with it a duty not just for us and our colleagues but also for our organisations to embed a culture of wellbeing, of care and of processes that support us to be our best.

Conclusion

This document is best approached as a reflective tool that couches how we use language within the framework of trauma informed principles. Redressing the imbalance of power is not easy work. The motivations to undertake this work lie in an understanding that there needs to be change, that the people who are using the services and systems and/or live in the community hold diverse wisdom.

We collectively understand that language as a tool of power rather than as a powerful tool adds to harm through continued stigmatisation, through exclusion and through being a 'hard to reach' service. We collectively stand together to change the system and deliver the services that people want to use because those services prevent harm, they mitigate the impact of harm that already happened and they do not add to harm.

References

Collins, H.K. (2023). When listening is spoken. Current Opinion in Psychology, 47.

Dunn, D. S. (2021). Understanding ableism and negative reactions to disability. Retrieved from https://www.apa.org/ed/precollege/psychology-teacher-network/introductory-psychology/ableism-negative-reactions-disability Accessed February 2023

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 21, 95-103.

Morrison, T. (1993) The Nobel Peace Prize in Literature. Retrieved from https://www.nobelprize.org/prizes/literature/1993/morrison/lecture/ Accessed February 2023

Porges, S. (2004). Neuroception: A Subconscious System for Detecting Threats and Safety Zero to Three, May, p. 19-24

For more information contact:

01924 317659

@ westyorkshire.ics@nhs.net

www.wypartnership.co.uk

@wypartnership

07811766006

West Yorkshire
Health and Care Partnership