Appendix F: Avoiding Practice Traps

Practice Trap*	When You Identify the Practice Trap, Change It To:
Fixing and wanting to be helpful to the point of not hearing the patient – thus reproducing abuse dynamics of trauma.	Listen with empathy, respect and patience.
Lecturing instead of listening: This is sometimes triggered by time pressures and the perceived necessity to provide ALL the information. This can make the patient feel disrespected and result in loss of collaboration.	Know when/how to give advice and when to just listen, empathize and give structured choice when appropriate.
Feeling overwhelmed can result from feeling pushed, especially when the patient's situation is so complex that it is hard to know where to start.	Focus on being in the moment. Practice and teach relaxation techniques. • Demonstrating a breathing exercise (e.g., box breathing, or taking a few deep breaths together) at the start of a visit to establish a clam tone and model a simple way to self-soothe.[32] Set boundaries by explaining the length of the visit, choose a priority to work on together, and schedule a follow up. • Use an incremental/longitudinal approach – small steps over time. • Set agendas for more frequent, shorter visits for complex medical issues. • Involve other care providers on the team. Consider reaching out to a colleague for support. • "I need time to think about it/talk to a colleague about it. I will get back to you."
Rigidity: belief that there is only one way for patients to recover.	Flexibility.
Believing that information alone can cause change	Appeal to the emotional instead of the rational (connect to heart). Refer to *Appendix G: Validating and Invalidating Statements and Curious Questions*.
Losing awareness of body language and facial expression can result in expressions of excessive sympathy, dismay, frustration or shock that can have an unintended impact on the conversation.	Be aware of common cues that may indicate a shame state. "These include postural and embodied cues (e.g., covering the face, blushing, downcast eyes, etc.), common terms used instead of shame (e.g., 'self-conscious', 'embarrassed', 'foolish', 'worthless', 'inept', 'inferior', etc.), paralinguistic cues (e.g., stammering, silence, long pauses, etc.). Practitioners must also become adept at recognising bypassed shame, through knowledge and recognition of common avoidance behaviours for shame."[33]

*Adapted from the BC Trauma-Informed Practice Guide: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf