

Trust Building & Maintenance

Deep Dive Modules · Leadership

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Part 1 · Overview

Trust Building & Maintenance

The Foundation of Effective Treatment Teams

From Fragile to Resilient — The Recovery Files

Fragile

Guarded, isolated, surviving

→

Resilient

Connected, collaborative, thriving

Reading Sections

The Neuroscience of Trust: Why Your Brain Takes Trust Personally

Self-Assessment

Worksheets & Exercises

Part 2 · What Is Trust — And Why It Matters in Treatment Teams

What Is Trust — And Why It Matters in Treatment Teams

Trust is the invisible infrastructure of every effective treatment team. It is not a feeling, though feelings accompany it. It is not a policy, though policies can support or undermine it. Trust is the operating system that determines whether a team of clinicians, counselors, and support staff functions as a genuinely collaborative unit or merely as a collection of individuals who happen to share the same building and the same client population.

In substance use disorder treatment, trust is not a luxury — it is a clinical necessity. The work we do requires coordinated vulnerability. We ask clients to disclose their deepest shame, their most dangerous secrets, their most painful truths. We ask them to trust the treatment process, to trust the team, and to trust that the people responsible for their care are working in genuine partnership with each other and with them. When the team behind that treatment is fractured by distrust — when clinicians withhold information from each other, when staff members feel unsafe to admit uncertainty, when disagreements go underground rather than being addressed directly — the treatment environment becomes contaminated. Clients sense it. They always sense it.

Trust among treatment team members operates on multiple levels simultaneously. There is competence trust: "I trust that you know what you are doing clinically." There is reliability trust: "I trust that you will follow through on what you commit to." There is benevolence trust: "I trust that you have good intentions toward me and toward the clients we serve." There is integrity trust: "I trust that you will act ethically even when it is difficult or costly." And there is vulnerability trust: "I trust that if I admit I do not know something, ask for help, or share a professional struggle, I will not be punished, shamed, or exploited for that disclosure."

Each of these trust dimensions is built differently, maintained differently, and damaged differently. Competence trust is built through demonstrated skill and sound judgment over time. Reliability trust is built through consistent follow-through on commitments large and small. Benevolence trust is built through genuine care and non-exploitative behavior. Integrity trust is built through alignment between stated values and actual behavior. Vulnerability trust — perhaps the most important for clinical teams — is built through repeated experiences of safety when taking interpersonal risks.

Here is what many professionals misunderstand about trust: it is not binary. It is not something you either have or do not have. Trust exists on a continuum, and it fluctuates based on context, history, and current conditions. A team member might trust a colleague's clinical competence completely while having very low trust in their emotional regulation during crisis situations. A supervisor might be trusted for their integrity but not for their follow-through on administrative commitments. Understanding these nuances is essential for accurate trust assessment and targeted trust building.

The treatment environment adds unique pressures to trust dynamics. Burnout erodes trust as exhausted professionals become less reliable, less patient, and less emotionally available.

Secondary traumatic stress affects interpersonal perception, making team members more hypervigilant, more irritable, and less charitable in their interpretations of others' behavior. High staff turnover creates trust instability as team members are repeatedly asked to build new relationships while grieving the loss of established ones. Organizational instability — policy changes, leadership transitions, funding uncertainty — can undermine even the strongest interpersonal trust by creating a context of systemic unpredictability.

Understanding trust as the foundation of team effectiveness is not soft science. Research consistently demonstrates that high-trust teams outperform low-trust teams on virtually every measure that matters in treatment settings: communication accuracy, clinical decision quality, staff retention, client satisfaction, and treatment outcomes. Trust is the infrastructure that makes everything else possible. Without it, even the most skilled clinicians, the most evidence-based protocols, and the most well-resourced treatment centers will underperform. With it, even teams facing significant resource constraints can deliver extraordinary care — because they are genuinely working together rather than merely occupying the same space.

Reflection Questions

1. How would you describe the current trust level on your team — on a scale of 1 to 10? What specific evidence supports your rating?

2. Which dimension of trust is strongest on your team (competence, reliability, benevolence, integrity, vulnerability)? Which is weakest? What impact does the weakest dimension have on team effectiveness?

3. Have you experienced a treatment team where deep trust existed among members? What was different about the quality of care in that environment compared to lower-trust teams?

4. How do the unique pressures of substance use disorder treatment — burnout, secondary trauma, high turnover — affect trust dynamics on your current team?

5. If your clients could see the level of trust among the professionals responsible for their care, what would they observe? Would that observation increase or decrease their confidence in treatment?

Part 3 · Why Trust Erodes: The Hidden Mechanics of Team Trust Damage

Why Trust Erodes: The Hidden Mechanics of Team Trust Damage

Trust does not typically collapse in a single dramatic event. It erodes. It wears away in small increments — in the unreturned message, the information withheld, the promise broken, the frustration vented to the wrong person, the feedback never given, the credit not shared, the mistake covered rather than acknowledged. Understanding the mechanics of trust erosion is essential because by the time trust damage becomes visible, the underlying structure has often been deteriorating for months or years.

The most common driver of trust erosion in treatment teams is inconsistency between words and actions. This is not usually intentional deception. It is the counselor who says "I'll get that assessment done by Friday" and doesn't, then doesn't acknowledge the broken commitment. It is the supervisor who says "My door is always open" but responds with visible irritation or distraction when someone actually walks through it. It is the colleague who says "We're a team" but consistently makes unilateral decisions without consultation. Each individual instance may seem small. But trust operates on pattern recognition — the human brain is constantly scanning for whether someone's behavior matches their stated intentions. Repeated mismatches accumulate into a fundamental credibility problem that no single conversation can repair.

Triangulation is perhaps the most destructive trust-eroding behavior in treatment teams, and it is endemic to helping professions. Triangulation occurs when Person A has a concern about Person B but discusses it with Person C instead of addressing it directly with Person B. The justification is usually some version of "I just need to vent" or "I wanted to get your perspective" — but the effect is corrosive. Person B is discussed without the opportunity to respond. Person C is placed in an uncomfortable middle position. And the original concern goes unresolved while the relational contamination spreads. Treatment teams are particularly susceptible to triangulation because clinicians are often more comfortable analyzing interpersonal dynamics than engaging in them — it is easier to process feelings about a colleague than to sit across from that colleague and have an honest, uncomfortable conversation.

Unaddressed power dynamics erode trust silently and systematically. In treatment settings, formal hierarchies (supervisor-supervisee, lead clinician-support staff, medical director-counselor) create power imbalances that profoundly affect trust perception. When someone in a position of authority asks "Does anyone have concerns?" the silence that follows is not necessarily agreement — it may be the strategic silence of people who have learned that raising concerns has consequences. The most insidious trust erosion occurs when leaders genuinely believe they have created an open environment while staff members experience that environment as psychologically unsafe. This gap between leadership perception and staff reality is one of the most common and damaging trust problems in treatment organizations.

Burnout and compassion fatigue are trust-eroding forces that are often underrecognized because they affect behavior gradually rather than suddenly. A clinician experiencing burnout becomes less patient, less present, and less reliable — not because their character has changed, but

because their capacity has been depleted. They start cutting corners. They become irritable in team meetings. They disengage from collaborative problem-solving. Colleagues experience these behavioral changes as trust violations — the person they counted on is no longer showing up in the same way — but the underlying cause (systemic depletion) is rarely addressed. Instead, interpersonal resentment builds as team members personalize what is actually an organizational failure to protect staff wellbeing.

Organizational betrayal is a distinct and powerful form of trust damage that occurs when institutions fail to protect the people who work for them. Treatment organizations betray staff trust when they promise resources and don't deliver, when they ask for feedback and then punish those who provide it, when they prioritize census numbers over clinical quality, when they change policies without consultation, or when they respond to staff concerns with dismissal or gaslighting. Organizational betrayal is particularly damaging because it removes the contextual safety that individual trust relationships depend upon. Even strong interpersonal trust between team members can be undermined when the organizational context communicates "this institution does not have your back."

The accumulation of unrepaired trust injuries is what transforms manageable problems into systemic dysfunction. Every trust-damaging event — every broken commitment, every instance of triangulation, every abuse of power, every organizational betrayal — creates a wound. If that wound is acknowledged and repaired, it can actually strengthen the relationship, just as a properly healed bone can become stronger at the fracture site. But when trust injuries go unacknowledged and unrepaired, they accumulate into scar tissue that makes future trust building progressively more difficult. Teams that have accumulated years of unrepaired trust damage often find themselves in a state of chronic, low-grade relational inflammation — functional enough to continue operating, but never healthy enough to provide the collaborative depth that excellent treatment requires.

Reflection Questions

1. Think about the last time trust eroded on your team. Was it a single event or a gradual process? What were the earliest signs you noticed — or missed?

2. How prevalent is triangulation on your current team? When you have a concern about a colleague, what is your honest default — direct conversation or discussing it with someone else first?

3. Where do power dynamics affect trust on your team? Are there people who remain silent in meetings not because they agree, but because they don't feel safe to disagree?

4. How has burnout or compassion fatigue affected trust patterns on your team? Have you noticed behavioral changes in yourself or colleagues that may be burnout-driven but are being experienced as trust violations?

5. Has your organization ever betrayed your trust? What happened, and how did it affect your willingness to invest in trust relationships within that system?

Part 4 · The Neuroscience of Trust: Why Your Brain Takes Trust Personally

The Neuroscience of Trust: Why Your Brain Takes Trust Personally

Understanding the neuroscience of trust transforms it from an abstract concept into a biological reality with concrete implications for how treatment teams function, communicate, and collaborate. Trust is not merely a psychological construct — it is a neurobiological state that fundamentally alters how the brain processes information, makes decisions, and responds to other people.

The neurochemical most closely associated with trust is oxytocin, sometimes called the "trust molecule." Research by Paul Zak and others has demonstrated that oxytocin levels increase during positive social interactions characterized by trust, cooperation, and reciprocity. When oxytocin is elevated, the brain becomes more willing to take social risks — to disclose, to cooperate, to extend benefit of the doubt. When a team environment fosters genuine trust, the neurochemical milieu literally changes, making collaboration easier, communication more open, and professional vulnerability less threatening. This is not metaphorical — it is measurable biochemistry.

Conversely, when trust is damaged or absent, the brain shifts into threat-detection mode. The amygdala — the brain's alarm system — becomes hyperactivated, scanning social interactions for potential danger. In a low-trust team environment, colleagues' ambiguous behaviors are interpreted through a threat lens: the delayed email response becomes "they're ignoring me," the private conversation between two team members becomes "they're talking about me," the supervisor's neutral expression becomes "they're disappointed in my work." This is not paranoia — it is the predictable response of a brain operating in a context it has classified as socially unsafe. The cognitive resources consumed by this constant social threat monitoring are resources that are not available for clinical reasoning, creative problem-solving, or empathic attunement with clients.

The prefrontal cortex — the brain region responsible for complex social cognition, perspective-taking, and impulse regulation — functions optimally in trust-rich environments. When the prefrontal cortex is not burdened by chronic threat monitoring, it can perform the sophisticated social computations that effective teamwork requires: understanding a colleague's perspective, anticipating how a clinical decision will affect other team members, regulating emotional responses during disagreements, and making nuanced ethical judgments. In low-trust environments, prefrontal function is compromised because the brain is diverting resources to the more primitive, survival-oriented limbic system. The practical implication is stark: clinicians operating in low-trust teams are literally less capable of the complex thinking their work demands.

Mirror neurons — the neural systems that allow us to understand and empathize with others' emotional states — are modulated by trust. In high-trust relationships, mirror neuron activation is enhanced, meaning we are better able to accurately read colleagues' emotional states, understand their perspectives, and respond empathically. In low-trust relationships, this system is

dampened. We become less accurate in reading others, more likely to project our own fears and assumptions onto their behavior, and less capable of the empathic attunement that both client care and collegial relationships require. This neurological reality explains why the same clinical team can seem like compassionate, attuned professionals in some contexts and cold, disconnected individuals in others — the trust context literally changes how their social brains function.

The neuroscience of trust also explains why trust repair is so difficult and requires sustained effort. Trust damage activates the brain's fear conditioning circuits — the same circuits involved in traumatic memory. Once the brain has classified a person or environment as unsafe, it encodes that classification with the same neurological priority it assigns to physical threats. This means that intellectual understanding ("I know they apologized and I should move on") does not automatically override the emotional-neurological classification ("my brain still flags this person as potentially dangerous"). Trust repair requires not just cognitive acknowledgment but the creation of new, repeated experiences of safety that gradually recondition the brain's threat classification. This is why a single apology, no matter how sincere, rarely restores trust to its previous level — the brain requires a pattern of trustworthy behavior, experienced over time, before it will reclassify the relationship as safe.

For treatment professionals, this neuroscience has immediate practical implications. First, the trust environment on your team is affecting your clinical performance whether you are aware of it or not. Second, investing in trust building is not a luxury or a team-building exercise — it is investing in the neurological conditions necessary for optimal professional functioning. Third, trust erosion is not just an interpersonal problem — it is a cognitive impairment that affects clinical judgment, empathic accuracy, and decision-making quality. And fourth, trust repair is a neurological process that requires patience, consistency, and sustained behavioral change — understanding this can prevent the frustration of expecting instant restoration after trust damage.

Reflection Questions

1. How does understanding the neuroscience of trust change your perspective on trust-related difficulties on your team? Does knowing it is neurobiological rather than just interpersonal shift anything?

2. Have you experienced the "threat lens" effect — interpreting colleagues' neutral or ambiguous behaviors as threatening when trust is low? Can you identify a specific recent example?

3. How might diminished prefrontal cortex function in low-trust environments be affecting your clinical decision-making, empathic accuracy, or professional judgment without you realizing it?

4. If trust repair is a neurological reconditioning process requiring sustained new experiences of safety, what does that mean for realistic expectations about rebuilding trust on your team?

5. Considering that the trust environment affects mirror neuron activation and empathic accuracy, how might team trust levels be directly impacting the quality of care your clients receive?

Part 5 · Building and Restoring Trust: From Theory to Daily Practice

Building and Restoring Trust: From Theory to Daily Practice

Building trust in a treatment team is not a project with a completion date. It is an ongoing practice — a set of behaviors executed daily, in small moments, that collectively create an environment where collaboration deepens, vulnerability becomes possible, and the team's capacity to serve clients expands beyond what any individual could achieve alone. The gap between understanding trust conceptually and practicing trust behaviorally is where most treatment teams fail.

Trust building begins with personal trustworthiness — the deliberate, consistent demonstration that you are someone who can be depended upon. This is simultaneously the simplest and most difficult aspect of trust building. It is simple because the behaviors are straightforward: do what you say you will do. Communicate honestly. Follow through on commitments. Acknowledge mistakes promptly. Treat confidential information with care. Show up consistently — physically, emotionally, and professionally. It is difficult because consistency is the requirement. Not occasional trustworthiness. Not trustworthiness when it is convenient. Not trustworthiness with certain colleagues but not others. Consistent, across-the-board, sustained trustworthiness that becomes so predictable it no longer requires conscious effort. This kind of reliability is rare precisely because it is demanding.

The role of vulnerability in trust building is often misunderstood in professional settings. Vulnerability does not mean oversharing personal information, processing your emotions in team meetings, or creating situations where colleagues feel obligated to provide emotional support. Professional vulnerability means acknowledging what you do not know. It means asking for help when you need it. It means admitting when you have made a mistake before someone else discovers it. It means sharing a clinical concern or uncertainty rather than pretending you have it all figured out. It means being willing to say "I disagree" in a room where disagreement is uncomfortable, and "I was wrong" when evidence demonstrates that you were. This kind of vulnerability is not weakness — it is the foundation upon which genuine collaborative trust is built, because it signals that you value truth and growth more than the appearance of invulnerability.

Transparency in communication is the oxygen supply of trust. Teams cannot maintain trust in an information vacuum. When information is withheld — whether about organizational changes, clinical decisions, scheduling considerations, or interpersonal concerns — the human brain fills the vacuum with speculation, and that speculation is almost always worse than the reality. Transparency does not mean sharing everything with everyone. It means sharing relevant information with the people who need it, explaining the reasoning behind decisions, acknowledging what you can and cannot share, and communicating proactively rather than waiting for people to discover things on their own. In treatment settings, where confidentiality creates legitimate limits on information sharing, being transparent about the existence of those limits paradoxically builds trust: "There are things I cannot share with you for confidentiality

reasons, but here is what I can tell you" is a trust-building statement precisely because of its honesty.

Trust repair after damage is perhaps the most important skill set for treatment teams, because no team avoids trust damage indefinitely. Mistakes happen. Commitments are broken. Communications fail. Conflicts erupt. The question is not whether trust will be damaged but what happens when it is. Effective trust repair follows a sequence: acknowledgment of the damage without minimization ("I understand that my failure to follow through on that commitment affected your work and your trust in me"), genuine accountability without excuse-making ("That was my responsibility and I dropped it"), expression of understanding about the impact ("I can see how that created extra work for you and made you question whether you could count on me"), concrete commitment to different behavior ("Here is specifically what I will do differently going forward"), and sustained follow-through that demonstrates the commitment was genuine. The most common failure in trust repair is stopping at the apology without sustained behavioral change — the brain does not recalibrate trust based on words alone.

Creating a trust-rich team culture requires deliberate, sustained attention to the small moments that constitute daily professional life. It means starting meetings by checking in with each other as human beings, not just reviewing tasks. It means explicitly naming when something feels unsafe in a conversation and addressing it rather than pressing through. It means celebrating when a team member demonstrates vulnerability rather than treating it as unremarkable. It means having regular conversations about how the team is functioning relationally, not just clinically. It means addressing trust concerns when they are small rather than waiting until they have become crises. And it means leadership that models every trust behavior it expects from others — because trust culture flows downward from leadership far more reliably than it flows upward from staff.

The ultimate aim of trust building in treatment teams is not the absence of conflict or the feeling of interpersonal comfort. It is the creation of an environment where professional differences can be aired honestly, where clinical complexity can be acknowledged without shame, where mistakes become learning opportunities rather than career threats, where diverse perspectives strengthen rather than fracture the team, and where the collective intelligence of the group exceeds what any individual member could generate alone. That is the treatment environment our clients deserve. And it is only possible when trust is treated not as a background assumption but as the most important thing the team deliberately builds and protects every day.

Reflection Questions

1. Where is the gap between your conceptual understanding of trust and your daily practice of trust-building behaviors? What specific behavior would close that gap most effectively?

2. How comfortable are you with professional vulnerability — admitting uncertainty, asking for help, acknowledging mistakes? What makes it harder and what would make it easier?

3. Think of a specific instance when trust was damaged on your team. Was it repaired effectively? If not, what step in the repair process was missed?

4. What "small moments" in your daily professional life could be leveraged as trust-building opportunities that you are currently missing or taking for granted?

5. Write a personal commitment statement for trust building — what are the three specific, observable behaviors you commit to practicing daily to build and maintain trust on your team?

Part 6 · Trust Building & Maintenance Self-Assessment

Trust Building & Maintenance Self-Assessment

Rate each statement: 1 (Not at all like me) to 5 (Very much like me)

I can accurately identify when trust genuinely exists among team members versus when relationships feel fragile or tentative

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I notice subtle signs that indicate whether team members feel safe to be vulnerable and honest with each other

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I understand the difference between surface-level professional cooperation and deep trust-based collaboration on my team

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can identify patterns in what creates trust resilience versus what makes trust relationships fragile and easily damaged

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I am aware of both the trusting and guarded aspects of current team relationship dynamics

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I recognize when colleagues are performing trust rather than genuinely experiencing it

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I notice when trust has shifted — improved or deteriorated — even when nothing has been explicitly said

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I am aware of how organizational culture and pressures affect trust quality among team members

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I am aware of my own behavioral patterns that either build or undermine trust with colleagues

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I consistently align my words and actions so that colleagues can depend on what I say

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I understand how my communication style and emotional responses impact team members' sense of safety

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can identify when I am demonstrating trustworthiness versus when I may be inadvertently damaging trust

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I manage my stress and fatigue in ways that do not erode colleagues' trust in my reliability

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I follow through on commitments even when circumstances make it difficult or inconvenient

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I am honest about my limitations rather than overpromising or pretending to know more than I do

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I treat information shared in confidence with the same care I would want for my own disclosures

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I communicate transparently with colleagues in ways that build rather than erode trust

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I notice when open communication creates safety versus when information withholding generates suspicion

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I honestly acknowledge mistakes and limitations in ways that strengthen rather than undermine my credibility

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I share information openly while maintaining appropriate confidentiality and professional boundaries

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I address disagreements directly rather than engaging in triangulation or behind-the-back communication

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I provide honest feedback to colleagues even when the conversation is uncomfortable

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I communicate about organizational changes and decisions in ways that preserve rather than damage team trust

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I am transparent about my reasoning when making decisions that affect team members

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I recognize early warning signs when trust is beginning to erode or become damaged within the team

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I notice behaviors and patterns that consistently undermine trust relationships among colleagues

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I understand how trust damage affects team functioning, communication, and collaborative effectiveness

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can identify situations and pressures that most threaten existing trust relationships on my team

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I notice when my own behavior under stress contributes to trust erosion among colleagues

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I am aware of how burnout, compassion fatigue, and secondary trauma affect trust dynamics on the team

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I recognize when organizational policies or leadership decisions are eroding team trust

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I notice when unresolved conflicts are silently undermining trust even when surface interactions appear normal

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I actively engage in trust repair when relationships have been damaged through mistakes or conflicts

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I know how to offer genuine apology and accountability that rebuilds rather than further erodes trust

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can learn from trust failures and implement concrete changes that prevent future damage

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I create psychological safety for colleagues to address trust concerns without fear of retaliation

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can navigate difficult repair conversations while maintaining respect and professional boundaries

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I model vulnerability in trust repair processes — owning my part without defensiveness

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I understand that trust repair is a process requiring sustained behavior change, not just a one-time conversation

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I support team-level trust restoration after organizational disruptions, leadership changes, or collective setbacks

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

1. Which domain scored highest? What does this tell you about your trust-building strengths?

Your reflection...

2. Which domain scored lowest? How is this affecting your team relationships and collaborative effectiveness right now?

Your reflection...

3. Which specific items did you rate as 1 or 2? These are your most urgent areas for trust-building development.

Your reflection...

4. Were any of your answers surprising? Did you discover a trust-building pattern you hadn't consciously recognized?

Your reflection...

5. Based on this assessment, what is the single most important change you need to make to strengthen trust on your team?

Your reflection...

Scoring guide

Reset all progress? This cannot be undone.

Higher scores across all domains indicate stronger trust-building capacity. Domains 1-4 assess your awareness and behavioral patterns. Domain 5 (Trust Repair & Restoration) assesses your ability to heal trust damage — often the most critical skill for long-term team health. The gap between your highest and lowest domain scores reveals where focused development will have the greatest impact on your team relationships.

Part 7 · Exercise 1: Trust Dimension Explorer

Trust Dimension Explorer

Trust Is Not One Thing, and It Is Not Binary

Five Dimensions, Built and Broken Differently

Most people answer the question "do you trust her?" with a single word, and the single word is almost always wrong. Competence trust, reliability trust, benevolence trust, integrity trust and vulnerability trust are five separate structures. They are built by different behaviors, damaged by different events, and repaired on different timelines. You can trust a colleague's clinical judgment completely and still not trust them with something you got wrong. That is not a contradiction. It is information, and it is only usable once you stop collapsing it into one word.

Pick one colleague you work with regularly and hold them in mind for this whole section. Not the easiest one and not the hardest.

1. Before you break it down: overall, how much do you trust this colleague?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

2. Now take the five dimensions one at a time for that same person. Competence — do you trust that they know what they are doing clinically? Reliability — do you trust that they will do what they said? Benevolence — do you trust their intentions toward you and toward clients? Integrity — do you trust them to act ethically when it is costly? Vulnerability — do you trust that admitting something to them would not be used against you? Give each one a rating out of ten and a sentence of evidence.

Be specific and honest...

3. Look at the five numbers next to the single number you gave first. Which dimension was your overall rating actually measuring, and which ones did it hide?

Be specific and honest...

1. Which dimension is strongest across your whole team, not just with this one colleague? What specific behaviors built it?

Be specific and honest...

2. Teams tend to be strong where they have been tested and came through. What did this team survive together that earned that dimension?

Be specific and honest...

The reading argues that vulnerability trust is the most important dimension for clinical teams and the one most often missing. Test that against your own team rather than accepting it.

1. On this team, how safe is it to say "I do not know what to do with this client" out loud, in a room with colleagues in it?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

2. Which dimension is weakest on your team, and what does the weakness cost in practical terms — what does not get said, asked, or escalated because of it?

Be specific and honest...

3. Is the weakness general, or is it specific to certain people or certain rooms? Be exact. "Nobody admits uncertainty in front of the medical director" is more useful than "we have low vulnerability trust".

Be specific and honest...

The reading names a common shape: high competence trust alongside low trust in someone's emotional regulation under crisis. Asymmetries are normal. Unnamed ones are expensive.

1. Name one relationship on your team with a real asymmetry — high on one dimension, low on another. How do you currently work around the low one without saying so?

Be specific and honest...

2. Now turn it around. Where do you suspect a colleague trusts you on some dimensions and not on others? Which one do you think is your low score, and what would they cite as evidence?

Be specific and honest...

1. The reading names burnout, secondary traumatic stress, turnover and organizational instability as pressures specific to this field. Which of the four is most active on your team right now, and which trust dimension is it eroding first?

Be specific and honest...

2. Think of the same team eighteen months ago. Which dimension has moved most, in either direction, and what moved it?

Be specific and honest...

Part 8 · Exercise 2: Team Trust Relationship Map

Team Trust Relationship Map

Where the Trust Actually Runs, and Where It Stops

The Map Is Not the Org Chart

Every treatment team has two structures running at once. One is the org chart — who reports to whom, who sits in which meeting. The other is the trust map — who actually tells whom the truth, who gets consulted before a hard call, who is told about a mistake first and who is told last. Care flows along the second map, not the first. Most teams have never drawn it, which is why the gaps are usually discovered by a client.

Write the actual names, or initials if that is more comfortable. Vague entries produce a vague map and a vague map changes nothing.

1. List every person whose trust in you, or yours in them, materially affects a client's care. Include support staff, admin, and anyone in another department you depend on. Most people under-count this list badly.

Be specific and honest...

2. Now mark each name: who do you go to first when something is genuinely difficult, and who is on the list but never gets consulted? What decided that?

Be specific and honest...

1. Take your two highest-trust working relationships. What specifically built them? Look for events, not qualities — a time one of you was covered for, a disagreement handled well, a mistake met without punishment.

Be specific and honest...

2. What does the team get out of those two relationships that it would lose if either person left tomorrow? Name the concrete things, including the ones that are not in anyone's job description.

Be specific and honest...

This is the section people write carefully and dishonestly. Write it as if nobody will read it, because nobody will.

1. How much of your working week is spent managing around a relationship rather than working through it?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

2. Name the lowest-trust relationship you have at work. What is the specific history — the event or the pattern — rather than the character judgment you have built on top of it?

Be specific and honest...

3. What does that relationship cost a client? Trace one concrete path: information that does not get passed, a consult that does not happen, a handoff that goes thin.

Be specific and honest...

A relationship's direction of travel matters more than its current level. A six that is falling is a bigger problem than a four that is climbing.

1. Which relationship on your map is improving, and what caused the change? Improvement almost always has a traceable cause, and it is usually smaller than people expect.

Be specific and honest...

2. Which is deteriorating? How long has it been deteriorating, and what have you decided — actively or by default — to do about it so far?

Be specific and honest...

1. Choose one relationship from this map to work on. Not the worst one — the one where a change would most improve client care. Name it and say why you picked it over the worst one.

Be specific and honest...

2. What is the first observable move, and when does it happen? An opening sentence, a request for ten minutes, a piece of information you have been holding. Write the actual words.

Be specific and honest...

Part 9 · Exercise 3: Personal Trustworthiness Inventory

Personal Trustworthiness Inventory

The Half of Team Trust You Control Completely

Simple, and Therefore Difficult

The behaviors are not complicated: do what you said, tell the truth, own the mistake before it is discovered, hold what was told to you in confidence. Everyone reading that list already knew it. What makes trustworthiness rare is not the difficulty of any single behavior — it is the requirement that it hold consistently, with everyone, including on the days you are depleted and the people you find difficult. Occasional trustworthiness does not accumulate. The brain scores the pattern, not the best instance.

1. When you say you will do something by a date, how reliably does it happen by that date without a reminder?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

2. Name a phrase you say regularly that your behavior does not fully back — "my door is always open", "just let me know", "I will look at that today". Everyone has one. What is yours, and what happens when someone takes you at your word?

Be specific and honest...

3. Name a commitment you made in the last month and did not keep on time. Did you acknowledge it, or did you let it pass quietly and hope it was not noticed?

Be specific and honest...

Trustworthiness that varies by audience is not trustworthiness. It is politics, and the people on its low end always know.

1. Who on your team gets your most reliable version, and who gets the version that slips? Be honest about the difference. It is usually about status, comfort, or how much someone can do for you.

Be specific and honest...

2. Is there anyone whose messages you deprioritize, whose requests you deliver late, or whose meetings you attend less prepared? What have they learned to expect from you?

Be specific and honest...

The reading is direct about this: burnout changes behavior before it changes character, and colleagues experience the behavior as a trust violation whatever caused it.

1. On your hardest weeks, how close does your behavior toward colleagues stay to your behavior on your best weeks?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

2. What specifically changes about you under pressure? Shorter replies, sharper tone, disengagement in meetings, corners cut in documentation, disappearing from the collaborative work. Name the ones that are actually yours.

Be specific and honest...

3. Who has been on the receiving end of that most often, and have you ever named it to them? Naming depletion out loud is a trust behavior; expecting people to absorb it silently is not.

Be specific and honest...

1. If a colleague were asked "can you count on this person?", what evidence would they cite for yes? Write their answer, not yours, and only include things they have actually seen.

Be specific and honest...

2. What evidence would they cite for the caveat — the "yes, but"? Everyone has a but. Write theirs, then decide whether it is fair, and what you will do about it either way.

Be specific and honest...

Part 10 · Exercise 4: Trust Erosion Pattern Analysis

Trust Erosion Pattern Analysis

The Five Mechanics, Traced On Your Own Team

It Erodes, It Does Not Collapse

Teams look for the incident. There usually is not one. Trust wears away through the unreturned message, the information withheld, the frustration vented to the wrong person, the mistake covered rather than named — none of which is large enough to raise at a meeting, and all of which the brain is quietly counting. By the time trust damage is visible enough to discuss, the structure underneath has been deteriorating for months. This exercise works the five mechanics from the reading one at a time, because the general question — "how is trust on the team?" — reliably produces a general answer that changes nothing.

1. Where on your team is there a visible gap between what is said and what happens? Quote the stated version and describe the actual version beside it.

Be specific and honest...

2. Has anyone named that gap out loud, or is everyone working around it privately? What happens on this team to a person who names it?

Be specific and honest...

The reading calls this the most destructive trust-eroding behavior in treatment teams, and says helping professions are especially prone to it — it is easier to process feelings about a colleague than to sit across from them.

1. When you have a concern about a colleague, how often does it go to that colleague first rather than to someone else?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

2. Describe the last time you discussed a concern about someone with a third person instead of with them. What was the justification you used at the time, and what did it actually accomplish? Be specific and honest...

3. Where does triangulation concentrate on your team — which pairs, which topics, which room does it happen in? It is rarely evenly distributed.

Be specific and honest...

The reading names the most insidious version: leaders who sincerely believe they have created an open environment, and staff who experience that same environment as unsafe.

1. Think of the last time someone senior asked "does anyone have concerns?" and the room was quiet. Was that agreement, or was it the silence of people who have learned what raising a concern costs? What do you know that the person asking does not?

Be specific and honest...

2. Where do you sit in the hierarchy, and where does your own power distort what people tell you? Everyone has someone below them on some axis. What do you suspect you are not being told?

Be specific and honest...

A depleted clinician becomes less patient, less present, less reliable. Colleagues experience that as a trust violation. The cause is usually systemic and the resentment is almost always personal.

1. How much of the current interpersonal friction on your team do you believe is depletion rather than character?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

2. Name someone whose behavior has changed in the last six months in a way the team has taken personally. What is the more likely explanation, and has anyone checked?

Be specific and honest...

3. What would it take for your team to treat depletion as an organizational problem rather than an interpersonal one? Name the first conversation that would have to happen and who could start it.

Be specific and honest...

This form of damage is distinct because it removes the contextual safety that individual trust relationships rely on. Strong relationships between colleagues do not survive indefinitely inside a system that communicates "we do not have your back".

1. Has your organization promised something and not delivered, asked for feedback and then punished it, or changed something significant without consultation? Describe what happened, factually.

Be specific and honest...

2. How did that event change your willingness to invest in trust relationships inside this system? Be specific about what you stopped doing afterward — most people can name it once they look.

Be specific and honest...

Part 11 · Exercise 5: Trust Repair Action Planning

Trust Repair Action Planning

One Injury, Worked Through the Full Sequence

A Properly Healed Fracture

No team avoids trust damage. The question was never whether it happens but what follows it. A trust injury that is acknowledged and repaired can leave the relationship stronger at the break, the way a properly healed bone does. A trust injury left unrepaired becomes scar tissue, and enough scar tissue produces the state most struggling teams are actually in: functional enough to keep operating, never healthy enough to do the collaborative work good treatment requires. This exercise takes one real injury through the full sequence, because the most common repair failure is stopping at the apology.

Choose something real and still live. Prefer one where you did the damage — those are the ones you can actually repair.

1. Describe what happened, in plain factual terms and without the framing that makes you look better. What did you do or fail to do, and when?

Be specific and honest...

2. How long ago was it, and what has happened between you since? Silence counts as something that happened.

Be specific and honest...

The first step is naming the damage, not explaining it. An explanation offered before an acknowledgment reads as a defense, however true it is.

1. Write the acknowledgment sentence. Name what you did and that it affected them, with no "but", no context, and no reference to how busy you were.

Be specific and honest...

2. Now write down the explanation you want to give — the reasons, the pressures, the other person's part. Get it out here. Then decide whether any of it belongs in the conversation, and if so, how much later.

Be specific and honest...

1. What did this actually cost them? Extra work, exposure in front of others, a client who suffered, a question about whether you can be relied on. Name the specific costs rather than saying "I know it was frustrating".

Be specific and honest...

2. Which trust dimension did you damage — competence, reliability, benevolence, integrity, or vulnerability? Repair aimed at the wrong dimension does not land.

Be specific and honest...

This is the step teams skip, and it is the only one the other person's brain is actually measuring.

1. How confident are you that you will not do this same thing again in the next three months?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

2. What specifically will be different, stated so that someone else could tell whether it happened? "I will be more careful" is not it. "I will send you the note by end of day Wednesday every week" is.

Be specific and honest...

3. What has to change structurally for that to hold on a bad week — a system, a reminder, a reduced commitment elsewhere? Intentions that depend on a good week do not survive.

Be specific and honest...

The neuroscience reading is blunt about this: trust damage is encoded in the same circuits as threat learning, so intellectual acceptance does not override it. The other person's brain needs repeated new experiences of safety before it reclassifies you.

1. How long are you willing to demonstrate the change before you expect the relationship to feel normal again? Write a real number of weeks, and notice your reaction to it.

Be specific and honest...

2. What will you do if they stay guarded after you have done everything right? That reaction is neurological, not a verdict on your sincerity — write what you will tell yourself so you do not withdraw the repair halfway through.

Be specific and honest...

Part 12 · Exercise 6: Professional Vulnerability Practice

Professional Vulnerability Practice

Saying the Thing That Costs Something to Say

Not Oversharing — Something Harder

Professional vulnerability is routinely confused with emotional disclosure, and the confusion is convenient, because it lets people avoid the real thing while feeling they have considered it. It does not mean processing your feelings in a team meeting. It means saying "I do not know". It means asking for help before the situation forces you to. It means naming your own mistake before someone else finds it, saying "I disagree" in a room where disagreement is expensive, and saying "I was wrong" when the evidence says so. It is not weakness. It is the signal that you value being right less than getting it right, and it is the only thing that makes a team safe enough to say difficult things out loud.

1. Where is the line for you between professional vulnerability and disclosure that puts a burden on colleagues? Write your own working rule, one you could apply in the moment.

Be specific and honest...

2. Which side do you err on — too guarded, or too open? What has that cost you, and what has it cost the people around you?

Be specific and honest...

In a field where clients are asked to disclose their worst secrets to us, clinicians are strikingly reluctant to admit uncertainty to each other.

1. How comfortable are you saying "I do not know what to do here" in front of your team?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

2. Name a current case where you are less certain than you have let on. What have you been doing instead of asking — reading around it, waiting, hoping it resolves?

Be specific and honest...

3. What are you protecting by not asking? Reputation, a supervisor's opinion, your own sense of competence. Name it plainly, then weigh it against what the client is getting in the meantime.

Be specific and honest...

1. Recall a recent meeting where you disagreed and did not say so. What was the decision, what was your objection, and what happened afterward?

Be specific and honest...

2. Write what you would have said, as an actual sentence you could deliver out loud. Then note what you would need — timing, an ally, a private word first — to say the next one.

Be specific and honest...

1. Choose one act of professional vulnerability for this week: an admission of uncertainty, a request for help, an acknowledged mistake, or a stated disagreement. Name it, name the person, name the day.

Be specific and honest...

2. What is the worst realistic outcome, and could you survive it? Then write what you expect the likely outcome actually is. The gap between those two answers is usually where the reluctance lives.

Be specific and honest...

Part 13 · Exercise 7: Trust-Building Communication Toolkit

Trust-Building Communication Toolkit

The Sentences and Habits You Will Actually Use

Trust Is Built in Sentences, Not Intentions

Everyone intends to be trustworthy. What separates teams is whether anyone has the specific words ready when the moment arrives — when a colleague is late with something and you have to choose between an assumption and a question, when you have got something wrong and the explanation is already forming, when a room goes quiet and someone has to say so. Select what would survive in your actual setting, write your own where the list does not fit, then pick the one you will use this week.

Reliability trust is built in small, boring increments. Which of these would actually survive your worst week, not your best one?

Write this in your own words — the version you would actually say out loud, in your voice:

The words you would use, and the moment you would use them...

Information vacuums fill with speculation, and the speculation is almost always worse than the truth. Which practices keep the vacuum from forming?

Write this in your own words — the version you would actually say out loud, in your voice:

The words you would use, and the moment you would use them...

Sentences short enough to use in the moment, when the temperature is up and the explanation is crowding the acknowledgment.

Write this in your own words — the version you would actually say out loud, in your voice:

The words you would use, and the moment you would use them...

The alternative to venting about a colleague is a sentence you can actually say to them. Choose the ones you would use, and write the rest yourself.

Write this in your own words — the version you would actually say out loud, in your voice:

The words you would use, and the moment you would use them...

The openings that make a room safe enough for someone else to go second. The first person to use one carries the cost; everyone after benefits.

Write this in your own words — the version you would actually say out loud, in your voice:

The words you would use, and the moment you would use them...

Trust culture is made of small recurring moments, not annual events. Which of these could your team realistically hold?

Write this in your own words — the version you would actually say out loud, in your voice:

The words you would use, and the moment you would use them...

1. Which sentence from this toolkit will you use first, with whom, and in what situation?

Make this concrete...

2. Which habit will you start regardless of whether anyone else on the team changes anything?

Make this concrete...

3. Who will you tell about this — the person allowed to notice when you are not doing it?

Make this concrete...

4. Write your personal trust commitment statement. One paragraph, in your own words, specific enough that a colleague could tell from the outside whether you were keeping it.

Make this concrete...

Part 14 · Exercise 8: Daily Trust Check-In (7 Days)

Daily Trust Check-In

7 Days of Small Deposits and Quiet Withdrawals

The Week Is More Honest Than the Reflection

Trust is not built or lost in the conversations people remember. It moves in the unremarkable exchanges — the message answered or not, the risk taken or swallowed, the assumption made about a closed door. Each of those is a small deposit or a quiet withdrawal, and none of them feels significant enough to record. That is exactly why they need recording. For seven days, take five minutes. The pattern across a week will tell you something a single honest reflection cannot.

One thing you did today that someone could count on. Small counts — a returned message, a note finished when you said it would be.

Your response...

One interpersonal risk you took: said you did not know, asked for help, disagreed out loud, owned a mistake. What happened after?

Your response...

One moment you read a colleague through the threat lens — an unanswered message, a closed door, a neutral face. What did your brain make of it, and what else could it have meant?

Your response...

A concern you took to the wrong person today, or one you took directly to the right one. Name it either way.

Your response...

Trust rating today (1 = guarded and scanning, 10 = safe enough to be honest)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Guarded · Safe to be honest

One thing you did today that someone could count on. Small counts — a returned message, a note finished when you said it would be.

Your response...

One interpersonal risk you took: said you did not know, asked for help, disagreed out loud, owned a mistake. What happened after?

Your response...

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Your response...

A concern you took to the wrong person today, or one you took directly to the right one. Name it either way.

Your response...

Trust rating today (1 = guarded and scanning, 10 = safe enough to be honest)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Guarded · Safe to be honest

1. Look at the seven ratings together. What is the range, and what separates your highest day from your lowest? The cause is usually nameable.

Review your week...

2. Count the interpersonal risks you took across the week. How many, and what happened after each one? Compare that to what you expected would happen.

Review your week...

3. How many threat-lens readings did you record, and how many did you ever check out with the person? What does that ratio tell you?

Review your week...

4. Where did concerns go this week — to the person, or around them? If they went around, to whom, and what did that accomplish?

Review your week...

5. Name the one change to how you work with colleagues that this week has earned. Make it small enough to start on Monday and specific enough that you would know if you had done it.

Review your week...

Part 15 • Exercise 9: Trust Fear Inventory

Trust Fear Inventory

What the Guard Is For, and What It Costs

The Guard Was Installed For a Reason

Nobody becomes guarded for no reason. Every professional carrying a habit of self-protection at work installed it in response to something — a disclosure that was used against them, a supervisor who punished a mistake, an organization that asked for honesty and then acted on it badly. The guard was accurate then. The question this exercise asks is whether it is accurate now, in this room, with these people, and what it is costing to keep it up if it is not. Nothing here is about deciding you were foolish to protect yourself.

1. Complete this honestly: "If I let this team see that I ____, then ____." Write three versions before you settle on the one that is true.

Be specific and honest...

2. Which is the bigger fear at work — being seen as incompetent, being seen as struggling, or being taken advantage of? What does each one make you hide?

Be specific and honest...

1. Where did this guard come from? Name the setting, the person, or the event. It may well predate this job and this field entirely.

Be specific and honest...

2. How accurate was that guard in the setting it was built for? Give it credit — it protected you from something real. What was it?

Be specific and honest...

The neuroscience reading describes what a brain does in a low-trust environment: the delayed reply becomes "they are ignoring me", the private conversation becomes "they are talking about me", the neutral face becomes disapproval. This is not paranoia. It is a threat-detection system doing exactly what it was built to do.

1. How often do you find yourself reading a colleague's neutral or ambiguous behavior as a signal about you?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

2. Describe a specific recent instance. What did you conclude, and what were the other explanations available at the time that you did not seriously consider?

Be specific and honest...

3. Did you ever find out what was actually going on? If not, what stopped you from asking — and what would asking have cost?

Be specific and honest...

1. The reading argues that constant social threat monitoring consumes cognitive resources that would otherwise go to clinical reasoning and empathic attunement. What is your guard costing you — in energy, in the quality of your thinking, in what you notice about a client?

Be specific and honest...

2. Where is the guard genuinely still warranted, and where is it running on a threat that has not existed for years? Be specific about which relationships fall on which side.

Be specific and honest...

Part 16 · Exercise 10: Trust-Treatment Quality Connection Map

Trust-Treatment Quality Connection Map

Tracing Team Trust Into Client Care

Clients Sense It. They Always Sense It.

It is tempting to treat team trust as an internal staff matter — pleasant when present, survivable when absent, unrelated to the clinical work. The readings do not support that. We ask clients to disclose their deepest shame and to trust that the people responsible for their care are working in genuine partnership. When the team behind that treatment is fractured, the treatment environment is contaminated, and the people in it notice long before anyone says so. This exercise is the one that turns trust from a staff-morale topic into a clinical one, which is the only framing that survives contact with a busy quarter.

1. If your clients could watch your team's internal interactions for one week, what would they see? Write it as they would describe it, not as you would.

Be specific and honest...

2. Would that observation increase or decrease their confidence in the treatment they are receiving? What single thing would they notice first?

Be specific and honest...

The reading claims that low trust diverts prefrontal resources into threat monitoring, and dampens the mirror-neuron systems that empathic accuracy depends on — meaning clinicians in low-trust teams are literally less capable of the thinking their work requires.

1. How much of your attention in a typical team meeting goes to reading the room rather than to the clinical content?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

2. Test the claim against yourself. Compare a period when you felt safe on a team with a period when you did not. Was your clinical thinking different? Where would you have seen it — in your notes, your case conceptualizations, your willingness to change your mind?

Be specific and honest...

3. If empathic accuracy is dampened in low-trust environments, and you spend your day using empathic accuracy on clients, what follows for the care your team currently provides? Say it plainly rather than softening it.

Be specific and honest...

1. Map the specific points where team trust touches a client directly: handoffs, case consultations, treatment-plan disagreements, coverage during absence, what gets written in a note versus what gets said in the corridor. Which of these is thinnest on your team?

Be specific and honest...

2. Name a piece of clinical information that did not travel as far as it should have in the last six months. What stopped it — time, or a relationship?

Be specific and honest...

Generalities let everyone off. Take one client and follow the thread all the way through.

1. Choose one client whose care was affected by something between staff rather than something about the client. Describe the sequence: what happened between which people, and what reached the client.

Be specific and honest...

2. What would have had to be different, between which two people, for that case to have gone differently? Name the relationship, not the policy.

Be specific and honest...

1. Write the case for team trust as you would make it to a director who considers it a soft concern and wants to talk about census. Use what you have written in this exercise. Two paragraphs, no jargon.

Be specific and honest...

2. What is the one change to how your team works together that you believe would most improve client outcomes? Name it, name who would have to agree, and name what you will do to raise it.

Be specific and honest...
