Caring Hearts

Beside you through grief's journey

Being Trauma Informed and Providing Trauma Informed Care

INTRODUCTION

As the title would indicate, being Trauma Informed and providing Trauma Informed Care (TIC) are two separate concepts. These concepts need to be considered by individuals and agencies which provide direct services to clients suffering from or having been exposed to trauma, who are traumatized, or who are exhibiting a traumatic response. In addition, individuals and agencies providing direct services which are not trauma related need to be Trauma Informed to understand how the thoughts, feelings and behaviors of traumatized clients may affect their own service delivery. Being trauma informed provides information so providers may know when it is appropriate to refer that client to another individual or agency which will address the trauma. To provide Trauma Informed Care (TIC) one must be Trauma Informed.

It is the intention of this writing to address both of these concepts. This document may serve as a companion to the video *TRAUMA INFORMED CARE AND TRAUMA*, hosted by Caring Hearts in Regina, Saskatchewan, Canada, and follows the format of the video. This document will provide the information necessary to be Trauma Informed, and provide some guidance on how and individual or agency may provide trauma informed care.

Chapter One of this document defines trauma and Trauma Informed Care, and spends time discussing the elimination of power over relationships; a core issue of TIC.

Chapter Two provides the basic information about trauma, its characteristics, how we process it, the symptoms of traumatic response, how trauma effects the functioning of our brain, and how to work with it. This chapter also presents how a client's trauma may affect us through secondary trauma. The chapter ends discussing indicators that an individual is recovering from trauma and traumatic response. At the end of Chapter 2 the reader is Trauma Informed.

Chapter 3 presents information to educate the client about what is happening to them as a result of being exposed to trauma, and having a traumatic response. The chapter presents Stress Management and Resiliency, discusses when it is appropriate to focus on each of these, and gives practical tools and interventions that the client may use to reduce stress and build resilience. The chapter also discusses resilience for the family as a unit.

Chapter 4 focuses on how and agency takes care of their staff, recognizing that many of the staff have experienced their own trauma. If you work as an individual not associated with an agency, approach this information as self-care. This chapter further develops the concept of secondary trauma, revisits the concept of traumatic response as it pertains to the worker, and presents ideas and practical ways a staff member may take care of themselves.

Chapter 5 presents a basic framework for an agency to begin the process of incorporating and codifying the provision of Trauma Informed Care.

Congratulations on beginning a process that will result in the provision of service that is more beneficial to your clients, your staff and to your agency as a whole.

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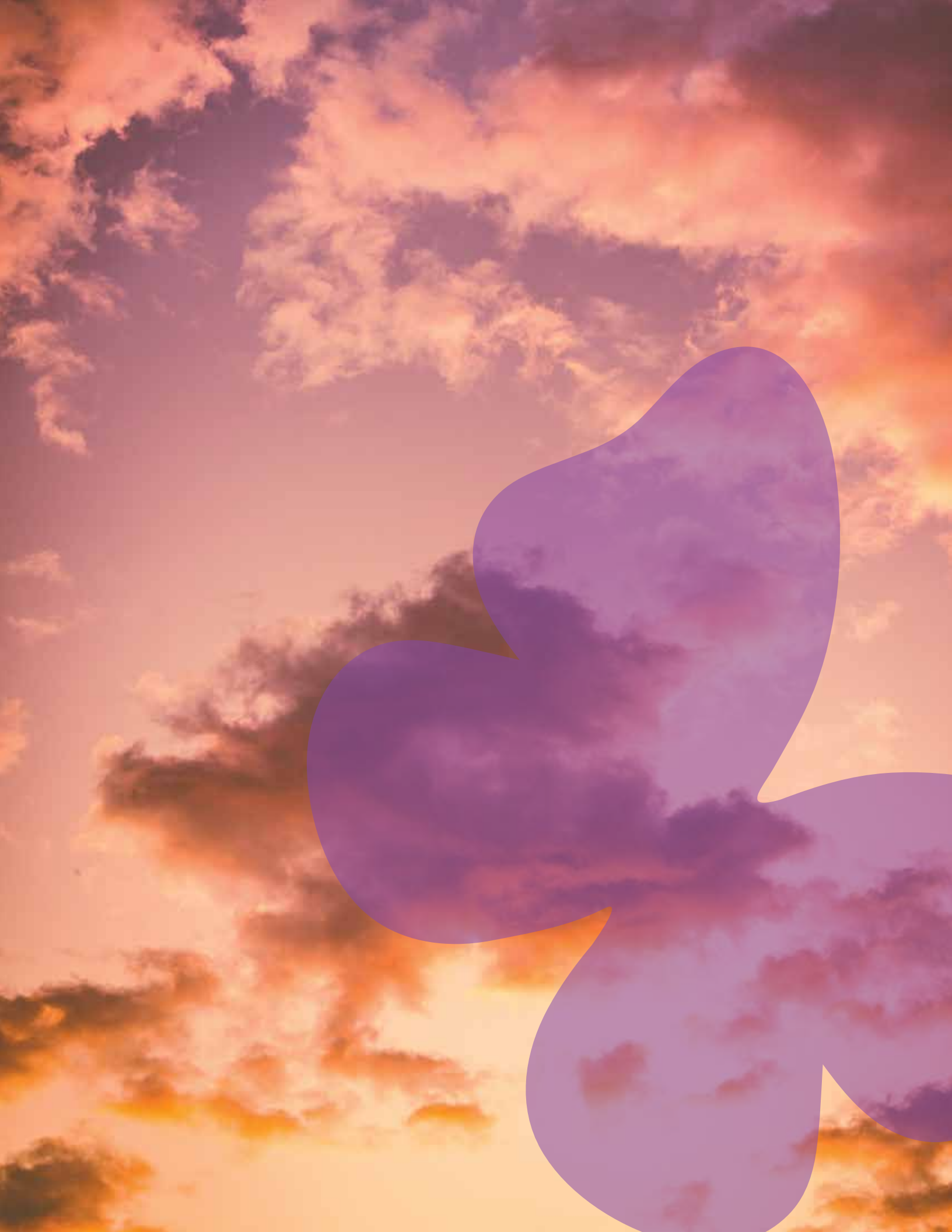

CHAPTER 1
What is Trauma Informed Care?

To understand why one should be Trauma Informed, or work to provided Trauma Informed Care (TIC), it is important that we understand what kinds of events or experiences are we referring to as traumatic? The Substance Abuse and Mental Health Services Administration of the US government has posted the following in their web-site as what they consider to be types of trauma and violence:

- Sexual Abuse or Assault
- Physical Abuse or Assault
- Emotional Abuse or Psychological Maltreatment
- Neglect
- Serious Accident, Illness, or Medical Procedure
- Victim or Witness to Domestic Violence
- Victim or Witness to Community Violence
- Historical Trauma
- School Violence
- Bullying
- Natural or Man-made Disasters
- Forced displacement
- War, Terrorism, or Political Violence
- Military Trauma
- Victim or Witness to Extreme Personal or Interpersonal Violence
- Traumatic Grief or Separation
- System-Induced Trauma and Re-traumatization.

As we look through this list we become aware of the fact that many of our clients have been exposed to at least one if not several of these experiences. As we look down the list it is important to make note of a few. For an example neglect is often defined as lacking emotional and/or physical proximity to care-giver, and we know that individuals who experienced neglect in the first two years of life will have mental health issues throughout their life. Also, being a witness of domestic or community violence reminds us of the powerful impact of secondary trauma, particularly on children.

Continuing down the list Historical Trauma helps to remind us that trauma experienced by ancestors and previous generations is passed on genetically, through learned behavior and even pre-natally. Forced displacement can include children removed and placed in foster care, being evicted from one's home or becoming a refugee for what ever reason. These same situations may also result in Traumatic Grief. System induced trauma includes all of the 'isms' that are represented, condoned or allowed by a culture, society or government.

Having seen this list of possible traumatic experiences, and recognizing that so many of our clients have experienced at least one of them, we begin to understand why it is important to deliver our service in a way that takes into account this traumatic exposure. So, Trauma Informed Care –

RECOGNIZES THE POSSIBILITY/ PROBABILITY THAT THE CLIENTS AND STAFF OF AN AGENCY HAVE EXPERIENCED TRAUMA IN THEIR LIFE, AND PROVIDES SERVICE IN A WAY TO ENSURE THAT IT DOES NOT TRIGGER A TRAUMATIC RESPONSE FROM THE PAST EXPERIENCE, OR CREATE A NEW TRAUMATIC RESPONSE.

TIC requires that an agency creates a service provision environment that ensures the trauma informed care of the clients and staff through practices, standard operating procedures, and policy. This process includes the elimination of 'power over relationships, educating staff about the etiology, assessment, characteristics and affects of trauma, educating the client about the role and affect of the trauma in their life, and empower

the client with emphasis on skill building and acquisition. TIC also focuses on the impact that a traumatized adult has on their environment, specifically children, and recognizing the symptoms, behaviors and appropriate interventions when the child themselves have experienced trauma.

ELIMINATION OF POWER OVER RELATIONSHIPS

Attention to the elimination of power over relationships is a major focus of TIC. An individual who is affected by trauma often feels that they had very little control over the experience, and feel they have very little control over their life as a result. When they seek out service from an agency or individual who imposes many rules and restrictions for a client to receive services, the individual is triggered by the control being taken from them again. The resulting behavior may be defiance, withdrawal, or a lack of engagement. This makes it more difficult to get the cooperation necessary from the client to provide them with our services.

The relationship should be one that empowers the client to feel they have at least equal status in the relationship. First, they need to be recognized as an individual and not as just another case or a number. Every effort should be made to refer to the client by name, and interest expressed in them personally beyond the service provision. Empowerment of the client is best established by giving the client as many choices as possible from where they want to sit in the room to details of receiving the service. "Where would you like to sit?" "Would you like some water?" We you like me to adjust the temperature?" "Should I call you Mrs. Jones or Bettye"? "Would you like to start the session by telling me what brought you here or would you like for me to ask a few questions to get us started?" These are all examples of choices that can be given to provide the client a sense of control and empowerment.

While rules need to be followed, they should be minimized or presented with options. This starts at the beginning of the client's experience with the agency. If the client walks into the agency and is faced with chairs in straight row, and signs saying 'No Smoking' or 'No Using of Cell Phones', or 'Please Wait until you are Called', and they are given a lengthy form to fill out with no explanation or opportunity to ask questions, they have experienced the agency exerting power over them in each instance. The alternative would be to walk in and see groupings of chairs, signs that say 'Thank you for choosing to use your cellphone outside', and being told "We are asking that you fill out this form so that we can begin the process of providing you with our services. If you have any questions or need any assistance please let me know and I would be glad to assist you."

Our goal should be to recognize that the client has probably experienced trauma and we need to provide a space that feels safe, empowers the client and gives them a sense of hope. We must be careful that we do not say things that they may interpret as shaming, and that we are working together equally to attain the same goal. We should provide the sense that we both win if the client receives the services they came to get.

CHAPTER 2
Educating You About Trauma

We continue the process of becoming trauma informed by educating you; the agency or office staff. By this, we mean the entire staff of the agency or office, paid volunteers and consultants. Everyone must have a basic knowledge of trauma because, as we've mentioned earlier, they may have experienced trauma, their co-workers may have experienced trauma and any visitor to the agency or office may have experienced trauma.

The first consideration is understanding what elements contribute to a person being a high risk for having a traumatic reaction to an event? Certainly the severity and duration of the event itself will impact the individual. Duration, for example, may be experienced differently by individuals. One individual may describe the event as lasting only a few moments while another individual may perceive it lasting an hour. It is important for us to remember that whatever duration the individual perceived is what is real for them.

A history of childhood abuse, whether physical, sexual or emotional may also cause a person to be a higher risk for an emotional response to an event. Research also indicates that this type of abuse results, later in adulthood, in the individual having a higher base level of stress than normal, and finds the individual more prone to avoid confrontation and conflictual situations. This behavior may lead the individual to being more likely to continue to be victimized. Research also shows that an individual with psychiatric illness, or having close family members with psychiatric illness are higher risk for a traumatic response to an event. Similarly, an individual with poor or negative social skills will be a higher risk for a traumatic response as well. One reason for this is that social support is a coping mechanism to deal with a traumatic response. A person with poor social skills will have a smaller social circle to draw on for that support.

Literature would lead you to believe that a person who uses or is addicted to substances such as drugs and alcohol is a higher risk for a traumatic response because of that use. However, those of us who have worked with addiction, or may have struggled with addiction ourselves, know that substance abuse is often used to self-medicate the symptoms of trauma. Despite the controversy as to which came first for the individual – the trauma or the substance abuse – if the individual abuses substances we should be aware that trauma may very well be in this person's history.

It is often thought that if a person has been previously exposed to trauma, they will handle subsequent exposure better for having had that experience. This is only true if the person dealt with the original trauma in a healthy way or sought out professional help. However, most people struggle through their first traumatic event with no professional support and using a trial and error method of coping. Often, they have adopted unhealthy behavior patterns and self-destructive coping mechanisms to cope. This pattern of behavior is then intensified if the individual has subsequent traumatic experiences. This in turn makes them higher risk for a traumatic response in the future.

The final characteristic that we will consider is the individual's inability to make attachments. As we said earlier, social support is one coping method for recovering from trauma. However, a person who cannot make attachments not only has no social network, they may not have family or significant other support as they do not have the ability to make attachments or sustain relationships. This may be the result of not having role models or being exposed to healthy relationships as a child. It could also be the result of the inability to utilize the oxytocin (the bonding hormone) in their system. This inability is often the result of the individual not

having received appropriate nurturing in the first two years of their life. This lack of nurturing inhibits the development of the ability to utilize oxytocin. With no ability to make or sustain meaningful relationships, the individual is high risk for having a traumatic response upon experiencing an event.

A traumatic response is usually the result of an event in which we believe we have no control, we do not feel safe and we do not believe that we are being heard or no one understands what we are experiencing. These are the three core issues of trauma.

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Having looked at the individual, it is now important to look at the event or the crisis itself to understand its impact on the individual's response. Research suggests that there are nine characteristics of the event that individuals evaluate to determine if the event is traumatic for them or not. This is, of course, a subconscious evaluation process, and is based on the individual's perception, which is a culmination of all of the life experience of that individual. Therefore, each individual's evaluation process will be unique. One of the characteristics is if the event had a warning. As we said above, for an event to be traumatic the individual must feel that they had no control. Depending on the individual's perspective, having a warning may have provided a sense of control over the response to the event.

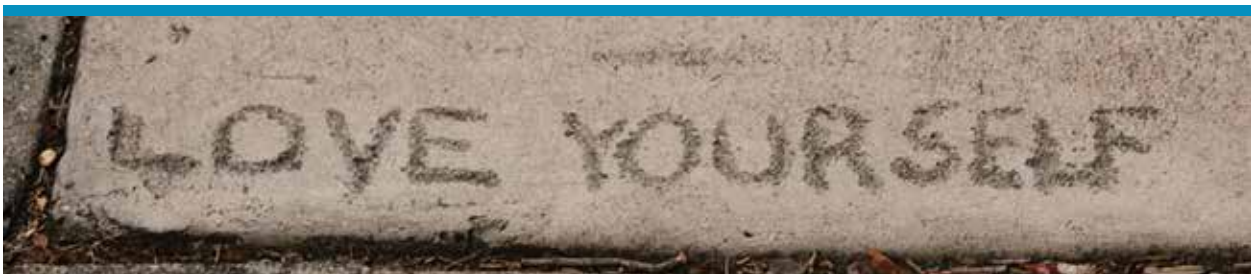
Another characteristic of the event that we consider is when it occurs; if it happen during the day or night. We have been conditioned to be afraid of the dark, partly because our sight is restricted without light. There may be fewer resources and people available late at night. For many reasons we perceive and react differently at night compared to day.

We have already discussed that the duration of an event may be perceived differently by the different people involved in the event. We also discussed that their perception of the duration is what is real for them.

Another characteristic that we may consider is whether the event was man-made or natural. A man-made event may have been able to have been controlled, and may not be perceived as traumatic. If it was man-made, was it intentional or could it have been prevented? Again, an event done intentionally as opposed to having been done by accident, or that could have been prevented, could have been controlled. When an event is man-made and perhaps intentional, the victim's reaction may be one of anger.

One major consideration an individual makes in reference to whether an event is traumatic is the scope of impact of the event; how many other people were affected? If the event was large scale such as a natural disaster, with many victims, then there are many people who understand what I am feeling and experiencing. I can be heard, which may reduce my perception of trauma. If I am the only victim of an event, I may perceive that no one understands what I'm going through and increase the potential of a traumatic response.

The post crisis environment is also an important component in the individual's evaluation process; what happened immediately after the event? Did help come quickly? Did people believe me? Blame me that it happened? How did they treat me? Was what happened immediately after the event also traumatic?



Was what happened immediately after the event also traumatic?

The final characteristic of the event that is used for evaluation is if the event caused the individual to suffer. This addresses the issue of not feeling safe. Suffering, by definition, refers to the meaning or value we give our pain. Everyone has pain, but individuals perceive their pain differently. Some suffer. For those who continue to suffer long after the event, it is very probable that they still do not feel safe.

So, having experienced a potentially traumatic event, our brain is using these nine characteristics to make the determination, based on the individual's perception, as to whether the event is traumatic for them or not.

Once the individual has determined that the event is traumatic, specific meaning and reaction is assigned to the event. First, the images and visual memories of the event become traumatic triggers; the thought of the images triggers the traumatic response within the brain and body. Second, the event is perceived as having happened suddenly or unexpectedly. If the individual knew that there was the possibility that the event could occur but they didn't know when, it was sudden. If the individual had no idea the event could occur, it would be unexpected. A third traumatic characteristic would be that the event is perceived as forceful or violent. In addition, the event is seen as overwhelming or uncontrolled. An individual feels overwhelmed when they have no hope, have no resilience and/or do not believe they can recover from the effects of the event. The final characteristic of this event now that it is traumatic is that it results in feelings of helplessness, lack of safety and lack of control. We have discussed these earlier. One way that victims feel unsafe, according to research, is that they are afraid of what people may think of them for having been in this traumatic situation.

Another way that we can understand the impact of trauma on an individual is through the use of Maslow's Hierarchy of Needs. Maslow suggested the basic, needs of a human (physiological;food, clothing, shelter) must be met before that individual can develop on into striving to meet their safety and security needs. This second level is where trauma has its impact, and until the individual begins to feel safe again following the traumatic event, they cannot develop on to address their belongingness and love needs. Grief over the loss of a loved one is an issue of the third level. Should a loved one have died in the traumatic event, the survivor has to resolve the fear of the trauma (level two) before they can begin to grieve the loss of the loved one (level three).

HIERARCHY OF NEEDS (Abraham Maslow)

SO, HOW DOES THE TRAUMATIC RESPONSE AFFECT THE INDIVIDUAL?

The characteristics of a traumatic response are cognitive, emotional, physical and mental. Cognitive in that it changes the way that we think, emotional in that it elicits strong feelings of fear, physical in that it affects how the hormones in our body react, and mental in that it changes the way that our brain functions.

We have talked a great deal about traumatic response to this point, and it is time that we clarify exactly what that means. To begin, we must understand that in the US there is only one accepted diagnosis for trauma, and that is the diagnosis known as Post Traumatic Stress Disorder (PTSD). If a client meets the diagnostic criteria for PTSD, it is considered the most intense level of being traumatized. Repeated exposure to the aversive details of trauma over time may lead to a diagnosis of PTSD. This would indicate that our physical, emotional, mental and cognitive reactions to this exposure builds over time, but may not yet meet the criteria for a diagnosis of PTSD. This building reaction from normal to PTSD over time is referred to as the traumatic response.

How do we know that we are experiencing a traumatic response? How is it measured? One of the physiological reactions to a traumatic response is the increase of the hormone cortisol in the system. There are blood and saliva tests for cortisol levels, but they tend to be expensive. The presence of cortisol in the system does result in specific symptoms, which are excellent indicators of a traumatic response. Traumatic response negatively affects:

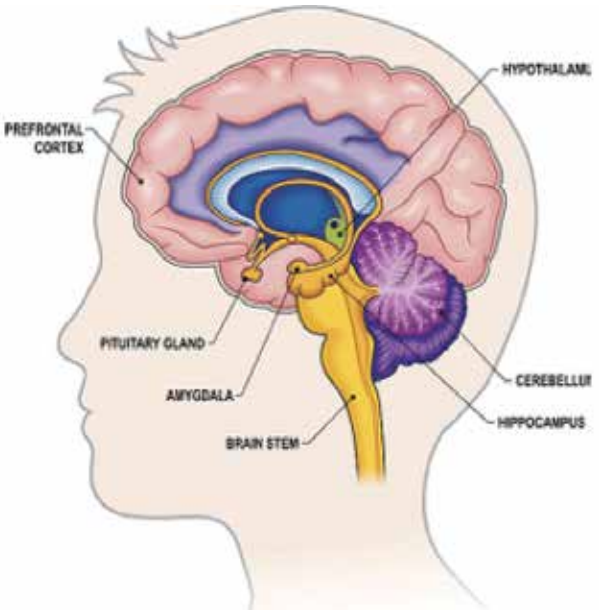
- CONCENTRATION
- MEMORY
- LEARNING
- REPETITIVE THINKING
- ANGER
- HYPERVIGILANCE
- SLEEP
- IMMUNE SYSTEM
- DISSOCIATION
- DETACHMENT

A traumatic response, resulting in the release of cortisol into the system results in difficulty concentrating, learning and with memory. Getting caught in memory or thinking loops, particularly about the trauma may develop. One may become angry more often with the anger response being greater than the situation might require. We may take on a very negative view of the world, expecting bad, negative or the worst thing to happen. This response can also negatively affect our ability to sleep and compromise our immune system. We may find that we feel like we don't fit in our environment, we begin to withdraw our feelings, and experience depression. (Note – the depression associated with trauma is not similar to clinical depression. Depression in this case is about a lack of motivation; not being able to get ourselves motivated to do what is necessary to attend or participate in events, even those in which we have a great desire to engage.) The stronger our reaction to the trauma, the more cortisol is released into the system. The greater the amount of cortisol in the system, the stronger and more pronounced these symptoms will become.

Now that we understand the physiological result of a traumatic reaction, let's look at how a traumatic reaction affects the way the brain functions. In the

illustration we see that the amygdala is attached to the hippocampus. What the illustration does not indicate is that we have two amygdalae and two hippocampi – one located in each hemisphere of the brain.

The amygdala is our fear and anger center and is responsible for initiating a traumatic response, and the fight-flight-freeze response. The amygdalae are constantly at work scanning all information coming into the brain from all of our senses, our feelings and thoughts. They are scanning for danger based on previous information stored in the brain. So, as new information comes in, if the amygdala finds something stored in the brain to associate danger to this new information, it will make that association and immediately react.



The hippocampus is the area of the brain associated with concentration, learning, and memory, and it serves as a sort of governor over the reaction of the amygdala. As an example let's say you find yourself at a deserted lake late at night, and it reminds you of a scene in a horror movie you once saw (the amygdala scanned the new information and associated it with stored information and raised the danger alarm). You begin to feel fear and uneasy. Your hippocampus is then activated and reminds you that memory was only a movie, and it wasn't real (it is governing the amygdala's action), and you calm back down.

Let's look more deeply at what just happened. When the amygdala made the connection with memory of the movie, it released a hormone to stimulate the hypothalamus, which released a hormone to stimulate the pituitary gland, which released a hormone into the blood stream to stimulate the adrenal gland which released adrenalin and cortisol into the system. This process of the hypothalamus-pituitary-adrenal gland is referred to as the HPA Axis. This is how cortisol is released into the system. The more the amygdala sounds the warning, the more cortisol is released into the system.

While this is happening, the hippocampus is trying to modulate the amygdala, but as we have seen, once cortisol is in the system it begins to interfere with the hippocampus and affect the ability to concentrate, learn, remember, etc. The hippocampus has regulators that only allow a certain amount of cortisol to affect its functioning. When cortisol reaches this amount, the hippocampus can stop the HPA Axis from releasing any more cortisol into the system. However, if the amygdala connects with so much danger information that indicates the person's life is in danger, it can over-ride and shut down the hippocampus. This is referred to as the fight-flight-freeze response; the person is now running on survival instinct (amygdala), without the interference of reasoning (hippocampus).

Cortisol levels can be reduced by the release of endorphins into the system, and there are several things that we can actively do to release endorphins. Exercise is one. The general rule for exercise is to do it a minimum of three times a week for a minimum of twenty minutes, breaking a sweat. The more you exercise, the more endorphins are released, the more cortisol is reduced, and the more the symptoms we discussed above are modulated or eliminated. Feeling good about yourself is another way to release endorphins. Set achievable goals for yourself and congratulate or reward yourself when they have been accomplished. We release endorphins when we feel nurtured, so having nurturing relationships are important. Finally, laughing releases endorphins. Actually, even pretending to laugh releases endorphins. Watching a video of puppies and babies, watching a silly slapstick comedy, or listening to a recording of people laughing may help you laugh as well.

There is another way that one's brain is affected by trauma as well. As you know the brain is divided into two hemispheres. The left hemisphere is considered the 'logical' side which provides for linear, step-by-step, logical thinking. It is the side of the brain that engages for mathematical calculation, planning and strategy. Your right brain is associated with creativity, imagination, being artistic or a visionary. When a person is exposed to trauma, the processing across the two hemispheres of the brain is affected, and functioning tends to become fixed in the right brain. Your response to that might be 'well that's not so bad, that's the creative side of the brain'. That is correct. It is also the side of the brain associated with images and the imagination. If it has been a trauma that has caused this brain to get stuck in the right hemisphere, what do you think the images are that the person is stuck on? What do you think the imagination is focusing on? The answer is traumatic images.

When a person's brain is fixed in right brain, they experience flashbacks, and have traumatic images in their head that they can't get rid of. We need to help the brain get un-stuck so that information will flow freely between both hemispheres via the corpus callosum. In the drawing of the brain above, the corpus callosum is in the very middle of the brain, light blue, in the shape of a fish hook laying on its side. The brain's processing of information across the corpus callosum is known as bi-lateral processing, and can be stimulated by the activity of the body. Activity on the right side of the body activates the left hemisphere, activity on the left side of the body stimulates the right hemisphere. So, any activity that utilizes both sides of the body in opposition causes the hemispheres to activate alternately as they should. Activity such as running, swimming, riding a bike, walking, using the elliptical exercise machine are examples of activities that are bi-lateral, and will stimulate the hemispheres to function correctly, and unfreeze from the right brain. This type of exercise, therefore, not only releases endorphins bringing down cortisol levels, but also helps to engage in bi-lateral processing.

As a result of experiencing trauma or a traumatic response, an individual may lose their sense of coherence, or sense of normalcy. It may be necessary for the individual to develop a new sense of normal. This is done by comprehending the world around them as it exists now, post trauma. As the individual recognizes and accepts how the world around them has changed, they must evaluate what different or new skills and resources they will need function within this new normal. And finally, the individual must decide if change is important enough to them to spend the energy necessary to change. It is important to note that this process is done from the individual's perspective, which is developed out of their life experience.

As a result of experiencing trauma or a traumatic response, an individual may lose their sense of coherence, or sense of normalcy. It may be necessary for the individual to develop a new sense of normal.

For mental health interventions to be effective in helping an individual to function within this new normal following trauma, four main considerations must be addressed. It is important to remember that two people may go through the same event, one may be traumatized, the other may not. The difference is the meaning and value that each are giving the event. Their meaning and value is based on their perception, which is based on their life experience. For a person who is significantly traumatized, the therapeutic goal is to help them perceive the trauma and its aftermath differently – to give it a different meaning or value. This is called cognitive restructuring. In therapy, this can only be accomplished if the relationship between the individual and the therapist is one in which the individual feels safe, in control and that they are being heard.

One of the first steps that a support person can take to establish a strong therapeutic relationship, and to begin the process of cognitive restructuring, is to assist the individual to take control over the responses they may be having to the memory of the event. This is done by assisting the individual in becoming aware of how their body and brain are reacting to the memories, and providing skills to regulate those reactions through stress reduction and relaxation techniques. Then, as the individual begins to bring up, talk about, and process these memories in therapy, they have the skills to regulate their reaction to them as they are working through the cognitive restructuring.

We have previously alluded to the diagnosis of Post Traumatic Stress Disorder (PTSD) above, but a more thorough discussion may be helpful. This discussion will be based on information from the Diagnostic Statistical Manual of Mental Disorders, fifth edited copyrighted in 2012 by the American Psychological Association.

To make a diagnosis of PTSD a therapist must consider several categories of criteria. The first is how the individual was exposed to the traumatic event. We will look at this criterion in more detail later. An evaluation is made as to if the memory or thoughts of the event are intruding into the individual's consciousness in way such as dreams, night mares and flashbacks. Is the individual engaged in extreme activity to attempt to avoid being reminded or triggered by memories of the event? And, supporters look at how the individual's world view may have changed to the negative as a result of this event.

Those providing support also look at arousal and activity such as an increase of anger, or difficulty sleeping. Evaluations also need to be made about the length of time the symptoms have been present, to what degree do the symptoms interfere with the individual's functioning, and to be sure that the symptoms are not being caused by something else such as drug use. There are specific sub-criteria that have to be met for each of these categories listed.

From the perspective of this diagnosis, the way we are exposed to trauma may vary. The traumatic event may happen to us, we may witness it happening to someone else, *we may learn that an event happened to a loved one or significant other, or we may be repeatedly exposed to the aversive details of a traumatic event*. It is this exposure that results in secondary trauma. Being exposed to the details of a traumatic event includes being repeatedly

exposed to the stories or evidence of other people's trauma. As this happens repeatedly, over time, you may move closer and closer to satisfying the other criteria for the diagnosis of PTSD.

Remember that PTSD may be the result of a single event, or the exposure over time to the aversive details of trauma. In the later, as you are being exposed, your body and brain are slowly being affected more and more as you approach PTSD. This change is referred to as a traumatic response. Attention to self-care and wellness, as in the reduction of cortisol discussed above, slow and eliminate traumatic response.

Secondary trauma occurs when we are exposed to someone else's trauma or traumatic event through our contact with them. This may happen in a variety of ways; the victim of the trauma tells us of the event, we read about the event or see images of the event are examples. As a result of this exposure to someone else's trauma, we begin to have a traumatic response as we begin to connect with the victim's feelings of having no control over the situation, not feeling safe and not being understood or heard. This then begins to affect the way that our body and brain respond, and the way we think and feel. We will look at secondary trauma in more detail later.

Just as a person providing support may be affected by secondary trauma as a result of someone else's trauma, a supporter can share in the healing and recovery of the client, or their Post Traumatic Growth. When the supporter connects with the feelings and joy of another's successes and recovery following a trauma, it is called Vicarious Post Traumatic Growth. We will look at this in detail later, but the growth is indicated in the person's positive change in:

- **Relating to others**
- **New possibilities as a result of the trauma**
- **Personal strength**
- **Spiritual change**
- **Appreciation for life and/or change in life priorities**

CHAPTER 3
Educating the Client About Trauma

Educating the client begins to move us from being Trauma Informed to providing Trauma Informed Care. This education begins with assisting the client in understanding how their current method of coping is a result of the things which happened to them in the past, and how they deal with the symptoms which they may still be experiencing is their coping. We assist in helping them improve this coping by helping them to identify the traumatic symptoms, the associated feelings, and the current coping. We teach anxiety management skills, and help the individual to identify and change mal-adaptive thought patterns. We assist in expanding the individual's ability to function by teaching improved interpersonal communication skills, and social interaction skills. And, we encourage the individual to advocate for themselves and for what they need.

Two terms that we hear most often when dealing with the effects of trauma are stress management and resilience. Stress management tends to be body oriented and focuses on physical activity that will reduce cortisol levels. However, stress management tends to be the actions that you take once you are already stressed. Resilience is living a lifestyle that does not allow you to become stressed. Rather than being specific things to do, it is on-going behavior and lifestyle.

Let's begin with stress management. First, we must recognize that stress is not necessarily bad. Stress is what motivates us to accomplish tasks and strive for goals. However, when the stress becomes intense enough that it is counterproductive, that it interferes with our motivation and goal achievement, it has become a problem and needs to be managed. Below is a list of de-stressing activities.

- Hang Up, Then Turn Off Your Phone
- Put On Some Music
- Eat One (ONE!) Candy
- Plug In
- Chew A Piece Of Gum
- Go for a 10 minute walk
- Breathe Deeply
- Visualize
- Eat A Snack (Mindfully!)
- Buy Yourself A Plant
- Step Away From The Screen
- Pucker Up
- Naam Yoga Hand Trick
- Progressive Muscle Relaxation
- Seriously, Turn Off Your Phone
- See Your BFF
- Eat A Banana (Or A Potato!)
- Craft
- Try Eagle Pose

Let's explore some of these. *Breathe Deeply* does a great deal to reduce stress. However, this can be taken even further if one exhales a couple of beats longer than they inhale. This will help the body to relax. *Visualize* takes into account that the brain does not know the difference between a visualized image and reality, and will respond to an image or vision as if it were real. If you intently visualize some place relaxing and connect to it with all five senses, your brain will believe it is real, and instruct your body to release endorphins and reduce cortisol. *Pucker up* refers to the fact that our stress is reduced when we are in the presence of someone who nurtures us. *Naam Hand Trick* is the application of pressure to the point between the pads at the base of the first and second fingers (on either hand). By applying pressure for five second intervals to this point, one can reduce their heart

rate, blood pressure, and metabolic rate. This point is on a meridian to the heart. Doctors are teaching this activity to folks after their first heart attack so that they are able to reduce the stress reaction in their body and slow their heart rate.

Plug In refers to finding relaxation websites on-line. *Progressive Muscle Relaxation (as well as Chew a Piece of Gum)* has the individual focus on and intensely tighten muscle groups up or down the body, then release them. When these muscles release, they become more relaxed than before the tightening. *See your BBF (Best Friend Forever)* is based on the understanding that social interaction with someone you care about distracts your attention from the stressor, is nurturing, and utilizes a part of the brain that counter-acts anxiety and depression. *Try Eagle Pose* refers to the practice of yoga which can be extremely de-stressing with the stretching and relaxing of muscles, and focus of thought.

As discussed earlier, resilience is more focused on behavior patterns and lifestyle. There are five core elements of resilience; self-knowledge and insight, sense of hope, healthy coping, strong relationships, and personal perspective and meaning. The more I know and understand myself the better I can prepare for stressful situations. Having a sense of hope counteracts fear and keeps me focused on forward movement. Incorporating stress management skills from the previous list as continual life-skills reduces the potential for me to become stressed. If one surrounds themselves with strong, healthy, positive friendships and relationships they will have a safety net to strengthen them when highly stressful/traumatic events occur. Finally, having a sense of purpose, self-worth and confidence of self provides one the inner strength and stability necessary to go through extreme situations.

A person who is resilient possesses a long list of positive characteristics. A resilient person has self-control in all situations, good problem-solving skills and emotional intelligence. They tend to be motivated to succeed, have good decision-making skills and are socially aware. Finally, people who are resilient are determined, and exhibit humor and faith.

Below is a list of activities that will help to build resilience.

- **Big four; exercise, relaxation, nutrition and rest**
- **Realistic expectations and goals**
- **Prioritize**
- **Live in the present**
- **De-clutter mind and environment**
- **Express gratitude**
- **Be Silent**
- **Optimistic about the future**
- **Volunteer**
- **Try something new**
- **Supportive people**
- **Make time for you**
- **Share responsibilities**
- **Meditate**

Many of these are self-explanatory, but we will expand on a few. *The Big Four* are stress management tools and are included to remind us that using stress management tools consistently is part of being resilient. As we *Prioritize* we need to remember that priorities do change, and we must be flexible and realistic as we set them. *Live in the present* is a Mindfulness technique that allows us to let go of regrets and disappointments of the past

and the expectations of the future and live fully in the moment. *Be silent* refers to the brain cells that grow in silence, not while being stimulated. *Meditate* does not have to be a rigid practice, but simply single pointed concentration where you lose connection with time and space – being in the zone. Any activity that you participate in and focus so intently that more time passes than you thought, and you have to reconnect with the space you are in is similar to meditating, and your body and mind have experienced the same benefits. Making as many of these as possible an on-going part of one's life-style will improve their resilience, as well as improve one's quality of life.

Just as an individual looks at several areas of their life to see if they are resilient, families have a set of criteria to determine if the family itself is resilient. It is very difficult for a resilient individual to maintain that resiliency while functioning with in a family that is not resilient.

The first criteria for consideration is the level of commitment each of the individual members have for the family. If the family or one of its members is facing a crisis, do all the other members drop what they are doing and come to focus on supporting the family? Or, do some continue what they are doing and connect with the family later on. Or are there others that never connect with the family through the crisis. How cohesive are the individual members? That is, how well do they mesh together when there is a crisis? Adaptability is a significant indicator of resilience; the more adaptable the more resilient. Does the family function according to a very strict set of rules, morals or values? Or does the family respond to situations on a case-by-case basis, being more adaptable?

Another indicator of family resilience is in its communication pattern. Do all members communicate well with all the other members, or do most of the communications of the family filter through one or two members to the rest? Filtered communication is not resilient. What kind of activity does the family participate in to makes the family feel fulfilled or grateful? How often does the family participate in this activity? Are all family members equally connected to all of the other family members? Or is the family composed of sets of dyads and triads of members connected to each other, with one or two members not connected at all? The more connections the more resilient. When the family is together socially, how do they interact. Are folks crowded around the TV so they don't have to talk to each other? Or are there groupings of folks interacting, and the groups dynamics constantly changing as people move from group to group? The latter shows resiliency. Finally, when the family works together on a goal, what is the outcome? Is it better or worse than expected, or right on target? When the majority of these criteria are functioning in a healthy way, the family is resilient and can withstand the most intense of challenges.

I would like to wrap up this chapter answering any question someone may have as to why it is so important to put so much attention on this subject of trauma, and allow it to drive staff interactions, staff/client interactions, or setting policy within an agency. Look at these:

ADULTS EXPOSED TO ABUSE AND TRAUMA DURING CHILDHOOD ARE

Adults exposed to abuse and trauma during childhood are:

- Almost 3 times more likely than non-abused adults to have an affective disorder.
- Almost 3 times as likely to have an anxiety disorder.

- Almost 2½ times as likely to have phobia.
- More than 10 times as likely to have a panic disorder.
- Almost 4 times as likely to have antisocial personality disorder.
- More likely to engage in self-harm -- suicide attempts, cutting, self-starving.
- More prone to experience auditory hallucinations and develop Schizophrenia.
- Much more likely to be homeless and mentally ill as adult women (97% of homeless, mentally ill women experienced severe physical and/or sexual abuse).
- At risk of developing PTSD or PTSD-related symptoms.

As for children:

- *Trauma perpetrated by a caregiver or involving witnessed threat to a caregiver are higher risk for traumatic response.*
- *For children, sexually violent events may include developmentally inappropriate sexual experiences without physical violence or injury.*
- *Childhood trauma may involve: Hyperactivity, inattention, impulsivity, extreme anger, paranoia, aggression, substance abuse, antisocial behavior, and attachment problems.*
- *The above symptoms may give rise to a variety of diagnoses, often without recognition of the underlying trauma*
- *PTSD can occur at any age beginning after the first year of life.*

These are just a few of the facts about trauma that help us to understand the importance of being trauma informed, and providing trauma informed care.

CHAPTER 4
Supporting Your Staff

We briefly discussed secondary trauma earlier. As stated, secondary trauma occurs when we are exposed to someone else's trauma or traumatic event through our contact with them. This may happen in a variety of ways; the victim of the trauma tells us of the event, we read about the event or seeing images of the event are examples. As a result of this exposure to someone else's trauma, we begin to have a traumatic response as we begin to connect with the victim's feelings of having no control over the situation, not feeling safe and not being understood or heard. This then begins to affect the way that our body and brain responds, and the way we think and feel.

For an example, our brain is wired to pick up on the feelings of others, and create a similar feeling within us based on our memories. This is accomplished through mirror neurons. It is believed that as mankind found that s/he could not survive as well on their own as s/he could in association with others, mirror neurons were developed so that s/he could understand the experiences and feelings of others, connect with those feelings from their own experience, and is better able to fit in with others. Mirror neurons are the basis of empathy.

Research has shown that experienced therapists use this feeling of connection to their client as an indicator of how effective they are being in the professional interaction with the client. Experienced therapists stated that if they do not feel some level of connection, they do not believe that they are providing adequate therapeutic support. However, these therapists also discussed the importance of not becoming too connected with the client so that they feel total responsibility for them or indebted/dependent on their success. Therapists did validate the importance of Vicarious Post Traumatic Growth.

Just as a person providing support may be affected by secondary trauma as a result of someone else's trauma, a supporter can share in the healing and recovery of the client or their Post Traumatic Growth. When the supporter connects with the feelings and joy of another's successes and recovery following a trauma, it is called Vicarious Post Traumatic Growth. Several behaviors are indicators of this growth. One is the indication that the client is improving in how they relate to people around them. Another is their ability to see new possibilities as a result of the traumatic event, and to recognize their personal strength as they move through their trauma. When the client acknowledges any spiritual change they have experienced as a result of this event, or verbalizes a change in their priorities in life, post traumatic growth is being exhibited. As they show movement in these areas, the supporter allows themselves a shared sense of accomplishment and success as well in having walked with the client through this process.

We have discussed traumatic response earlier as it pertained to the victim of a trauma. Now let's discuss it in terms of secondary trauma. For professionals being exposed to the aversive details of clients' traumatic events over time, their base cortisol level has risen over that time. Look again at the list of things that are negatively affected by increased cortisol. As this increase occurred over time, it may be difficult to recognize.

- CONCENTRATION
- MEMORY
- LEARNING
- REPETITIVE THINKING
- ANGER
- HYPERVIGILANCE
- SLEEP
- IMMUNE SYSTEM
- DISSOCIATION
- DETACHMENT

If you have been doing this work for some time ask yourself 'do I have more difficulty concentrating today than I did 2 years ago?' Ask yourself the same question for each item on the list. If you find that you have said 'yes' for one or two of them, you are probably normal. However, if you said yes for 3 or more, you are very likely having a traumatic response, and your base cortisol level has increased. But, as we discussed in an earlier chapter, this can be corrected by a consistent release of endorphins. As mentioned, exercise, feeling nurtured, laughing and feeling good about yourself all release endorphins and lower cortisol levels.

We have spent the past few pages focusing on ways to build and strengthen our self-care/stress management and wellness/resilience. However, occasionally we may be doing well and then just have a bad day, where it seems we have lost hold of all the work we have done. Don't despair. While we can expect that as we live more in wellness the bad days should be fewer and less frequent, we would not be human if we didn't have a 'bad day' every once in a while. When this occurs there is a tool that is very effective to help us get back on track – Mindfulness Techniques.

Situational Anxiety may indicate focus on the future. Situational Depression may indicate focus on the past. Mindfulness allows us to focus on and accept this moment for what it is; being able to let go of the event that just happened as well as any expectations for what's coming next. This allows us to move from event to event free of baggage or judgment, stress or emotion. We are existing in this moment.

The basic formula for Mindfulness Techniques can be described as S.T.O.P.

- Stop what you are doing.
- Take a breath. Take another, and another.
- Observe what you have been doing, thinking and feeling.
- Proceed with an activity that will distract and relax you for a short period of time (suggested below).

The focus of this type of Mindfulness activity is either your body, your environment or an object. Focus on any of these brings your awareness into the here and now.

The most common technique used to focus on the body is by observing one's breath. This can be done very easily by inhaling and feeling the air enter your lungs. Hold your breath for a couple of beats. Now exhale and feel the air leave your body. To add a dimension to this you might include a visualization of inhaling, feeling and imagining the air filling your entire body from head to toe. Hold the breath, then exhale imagining the air leaving all parts of your body. And, you can take this even deeper by inhaling and imagining that you are filling your body with healing light. Hold the breath and imagine the light shining out from within your body. Now exhale imagining that your breath is taking out all negativity, stress, and unhealthiness that you were holding. Which-ever of these you use, stay with it for about 10 breaths.

Focusing on your environment is an easier exercise. Simply focus for a few minutes on the space around you, and then invoke your five senses by asking 'what do I see?' Take a few minutes to list those things in your mind. Then ask 'what do I hear?'. Again list the sounds in your mind. 'What do I smell?' 'What do I taste?' 'What do I feel?' all follow the same pattern. Spend at least 7 minutes in this exercise.

Focusing on an object might be the most difficult of these three. Chose an object that is in your field of vision. It might be helpful if it is something that you can actually hold in your hand. Then you begin to ask yourself what it would be like to be that object? How would it feel to do the task for which it was intended? Spend at least 7 minutes in this exercise.

This brings us to the end of being trauma informed, and the direct service delivery of trauma informed care. Next we will look at the agency's process for providing Trauma Informed Care.

CHAPTER 5
Creating a Trauma Informed Service System

Once the agency is Trauma Informed, and has taken steps to be providing Trauma Informed Care, it needs to begin the process of codifying the work that has been accomplished. This is defined as creating a service provision environment that ensures the trauma informed care of the clients and staff through practices, standard operating procedures, and policy. This entails a thorough review of written policies and procedures as well as the non-written practices in how services is delivered. The review takes into account how this service delivery impacts the client and the staff. Specific effort is taken to eliminate any 'power-over' relationships or expressions that the agency may use in service delivery. Other issues to be addressed include:

1. Routinely screen for trauma exposure
2. Use culturally appropriate, evidence-based assessments and interventions for traumatic stress
3. Make resources available about trauma
4. Strengthen the resilience and protective factors of clients
5. Address caregiver trauma and its impact on the environment
6. Emphasize continuity of care for trauma across systems
7. Maintain care for staff that addresses secondary traumatic stress and increases staff resilience.

NOTE: These are generic guidelines suggested to all types of agencies. It is understood that they will be adapted to best fit an agency's specific service provision.

This process is often begun by the distribution of a survey instrument to staff, clients and customers of the agency. The survey will ascertain the knowledge base of these folks about trauma and the extent to which the agency may already be providing trauma informed care. There are many examples of such survey instruments on-line, and available through consulting companies which provide this as a service.

It is suggested that the survey collect information about trauma and traumatic stress in general, and as it pertains to mental health, culture, age, substance abuse, and how it affects body/brain/feelings and behavior. It should also gather information as to what staff are currently doing to support a client in trauma including identification of triggers, emotion regulation and management, and creation of safety plans and de-escalation. The survey should also glean information about how well staff is supported through team encounters, individual supervision, and on-going trauma education and consultation.

Other areas that the survey may include is the safety of the physical environment, how the agency shares information about trauma and being trauma informed, and whether the program is culturally competent for the population the agency serves. The client's privacy and confidentiality, safety planning, the degree to which communication between the client and agency is open and respectful as well as the agency's consistency and predictability may also be included.

The intake and assessment process is of major importance in evaluating the degree of trauma informed care of an agency. What information is gathered, how it is gathered, why it is being gathered, and observation as to how the client is reacting emotionally, mentally and physically during the assessment are all a major component to evaluating the level of an agency's trauma informed care.

The completion of the survey will now inform the agency what trauma informed care it does provide, and what it doesn't. The next step is to review

all standard operating procedures (SOP) and all written policies to determine if 1) all current written policies are being carried out and, 2) all the work that is actually being done is reflected in the SOPs and policies.

Now that all of the pertinent information has been gathered and updated, the next step is to expand the policies and SOPs to reflect the level of trauma informed care that the agency wishes to provide. The themes of 'feeling safe, feeling in control and being heard' should be repeatedly reflected. This then is codified, put in writing first, before attempting to implement. Members of the staff, client and customer community should be involved in this process.

The agency can now move into the application phase of providing trauma informed care. The first step of application is to educate the staff, clients and customers of what the agency policy is now in reference to providing care. This may be done in an environment that allows for comment and discussion. While this process is not necessarily seeking the approval of staff, clients and customers, their comments and feedback may raise relevant issues which need to be considered in the finalizing of the policies and SOPs.

Once all parties are familiar with the policies, it is time to introduce the training and infrastructure necessary to actualize them. An achievable goal-date should be set and publicized internally proclaiming when the agency will be fully functioning with respect to its trauma informed care standard.

There is one more step. It is necessary to include in the policy a consistent review of the care being given to ensure that it is meeting the policy guidelines. And, a review of the policies to determine if they are still relevant or need to be updated. Members of the staff, client and customer community should be involved in this process. It is suggested that this review occur every 2-3 years. Once again the review process should include members of the staff, client and customer community.

Congratulations! Your agency is now trauma informed and providing trauma informed care. It is our sincere wish that you find that the time and energy which your agency has put into this process is rewarded by the knowledge that you are serving your clients, customers and staff well.

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