Trauma-Informed Care Transcript

Introduction

Trauma-Informed Care

Trauma-Informed Care, developed by Dr. Valarie Whiting, statewide director of training and staff development for the Massachusetts Department of Developmental Services.

Course Features

[No audio, text reads: “This course features narration necessary to understand the material. Please ensure that your audio is working or use the closed captioning and transcript to follow along. You may also return to a slide or section of your choice by using the player menu.

There is also a quiz available for self-evaluation. Please go to the DDSLearning website at **https://www.ddslearning.com/** to locate the quiz under the ‘Trauma-Informed Thinking quiz’ tab”]

Learning About Trauma

This course covers material that may be difficult to hear and think about. You may find that learning about trauma brings back painful memories from your own life. Please feel free to step away from this course and take a break if you need to. Talk to trusted friends, colleagues, and medical professionals if you find this material very upsetting. This information is not meant to cause you any harm but to alert you to the necessity to learn from our past and discover how trauma affects everyone's life.

[Additional text: Crisis hotlines are available at: https://www.mass.gov/service-details/crisis-hotlines]

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Things to Remember

Here are some things to remember as you proceed through this lesson.

The content here will discuss trauma in terms of “what happened to you?” An approach that asks, “what is wrong with you”, is unproductive and can harm people. The symptoms we might identify as signs of trauma are an adaptation to traumatic events in our lives. It's vital to establish relationships with others through trust and communication. Healthy social relationships are the best environment to support healing from trauma.

Learning Goals

Our learning goals for this lesson include:

Helping you to develop a shared understanding of trauma, traumatic events, and the trauma histories of the people in our lives. To incorporate the Substance Abuse and Mental Health Service Administration, or SAMHSA, principles into your work and daily life. And, to consider organizational changes that may be required to be a more trauma-informed organization.

Section One: Understanding Trauma

What is Trauma?

This framework for understanding trauma was developed by a working group of researchers, practitioners, trauma survivors, and family members convened by SAMHSA. It is important because it creates a framework for understanding the complex nature of trauma. The definition they crafted states as follows:

> “Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or even life-threatening. These experiences can have lasting adverse effects on the individual's functioning and well-being, mentally, physically, socially, and spiritually.”

Some people prefer to use a more straightforward definition. For example: Trauma is anything that overwhelms a person's ability to cope.

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Three Es

The focus on events places the cause of trauma in the environment, not in some defect of the individual. This is what underlies the basic credo of trauma-informed approaches, "It's not what's wrong with you, but what happened to you."

The focus on experience highlights the fact that not every child or adult will experience the same events as traumatic.

The identification of a broad range of potential effects reminds us that our response must be holistic. It's not enough to focus on symptoms or behaviors. Our goal is to support a child to learn and grow, or an adult to live a satisfying life.

Traumatic Events

There is a wide range of events that can potentially cause trauma. Trauma can be caused by events that the individual doesn't remember, such as events that occurred in early childhood. Trauma can be caused by events that are well-intentioned and necessary, such as medical procedures. Trauma can also be caused by events that inform cultural or ethnic identity, for example, the experience of slavery, the Holocaust, or the genocide of Native American people. Over time, chronic stressors can accumulate to cause trauma, and many people experience multiple traumatic events over their lifespan. These events often shape a person's response to further stressors and trauma later in life. Chronic stressors like poverty, racism, or having a family member with a substance use disorder can inform a person's lived experience over months or years. Loss, such as the death of a loved one, abandonment, or loss of one's home or community due to war, also informs who a person becomes and how they respond to stress and trauma. Abuse, in all its forms, and violence are among the most serious traumatic events many people experience.

Experience of Trauma

The individual's experience of trauma may be profoundly affected by when, how, where, and how often it occurs. Trauma can be totally unintentional, such as when an organization does harm through its policies or procedures. For example, the routine practice of helping someone undress for a medical exam can re-traumatize a person. Systems can also unintentionally replicate the dynamics of earlier trauma, causing re-traumatization. Trauma can also occur from hearing about, watching, or interacting with others who have had traumatic experiences. Many caregivers experience this secondary traumatic stress. Trauma can result from a single devastating event, called single-

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episode trauma. This is also sometimes called acute trauma. Or, it can result from multiple traumatic events over time. Many individuals served by public services systems have complex trauma, which comes from experiencing multiple sources of trauma over a lifetime.

The context, expectations, and meaning assigned to an event or circumstance may determine whether or not the experience is traumatic. Even interventions that are necessary or life-saving may be experienced as traumatic. For example, medical interventions or removal from an abusive home can be traumatic. It can cause an association of trauma with specific locations or social dynamics. Humiliation, betrayal, or silencing may compound the traumatic experience, and frequency can impact the experience and severity of trauma. The individual experience of trauma is not necessarily conscious or recognized either by the individual or by others, and it may include physiological as well as cognitive experience.

Effect of Trauma

The effect of trauma on an individual can be conceptualized as a normal response to an abnormal situation. Trauma can have both short- and long-term effects and impact may not be immediately recognized. Trauma can affect an individual's coping responses or ability to engage in relationships or it can interfere with the mastery of developmental tasks. Trauma may affect an individual's physiological responses, psychological well-being, social relationships, or spiritual beliefs.

What about children who experience trauma a little later in childhood, those who have developed positive attachments and healthy relationship skills but then encounter trauma in one form or another? In contrast to the difficult or problem individuals we were just discussing, these people may not get much attention.

None of these signs is always associated with trauma. However, each of these signs can be adaptations to the neurobiological changes related to trauma. Even one of these signs should be enough to raise the possibility of trauma. Just being aware that what we sometimes call symptoms may be adaptations to underlying trauma can change the way we view children and families. These symptoms can continue into adulthood.

Signs of Trauma

On the following slides, we will review some of the common signs of trauma but note that none of these signs is always associated with trauma. Each of these signs can be adaptations to neurobiological changes caused, in part, by trauma, and that each of these behaviors can play an important role in the person's life. That's to say: They may protect the person in some way.

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We break these signs down into three areas: Behavioral, which manifests itself in a variety of behaviors based on the person's environment; Emotional and physical, which can cause someone to feel physically ill or exhibit heightened or unusual emotional responses; And, finally, psychological, which can cause someone to be in shock or denial after an event, or perhaps experience other ongoing problems.

Signs of Trauma: Behavioral

Behavioral issues can be difficult to comprehend. The way the person behaves may be unexpected or challenging, so it is vital to remember that there is always a reason for their behavior. Professionals, staff, families, and friends may need to examine the environment to understand why someone is acting the way they are. These signs might include blowing up when corrected or fighting when a peer criticizes or teases them. They might emerge as resistance to transitions or heightened sensitivity to change. Adaptations to trauma might lead a person to be overly protective of their personal space, engage in self-destructive behavior, or seeking attention frequently or in challenging ways. In some cases, a person might even revert to the responses you might expect from a younger individual.

Signs of Trauma: Emotional/Physical

Emotional and physical signs of trauma can occur just as frequently as behavioral signs. These signs might include nightmares and trouble sleeping or sensitivity to stimuli. They may be fearful of being separated from important people in their life or have difficulty trusting other people. The person might feel sad or angry or afraid, or all at once, and they may swing from one emotion to the next. These feelings can also be accompanied by a variety of physical symptoms or unexplained medical problems. Aches and pains, such as stomach and head aches, are common, especially in young people. This is also common for individuals with developmental or intellectual disabilities, especially when someone is unable to speak for themselves. This is one reason that a communication device may be so important to people who do not speak verbally.

Signs of Trauma: Psychological

Trauma is often the result of an overwhelming amount of stress that exceeds one's ability to cope with the emotions involved with that experience. This may contribute to psychological disorders. Signs of trauma commonly include problems with anxiety and depression. The individual may always feel unsafe or be on the lookout for warnings of potential danger or may alternately show a lack of understanding of what situations are safe and which are dangerous. They may have difficulty with cognitive abilities, such as focus, or with imagining the future. Dissociation can occur, leading the person to isolate and disengage from their surroundings.

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Other Signs of Trauma

Other signs of trauma can include unwanted persistent memories, loss of memories from periods of the person's life, the anticipation of negative experiences, excessive emotional responses, or lack of emotion. Because these signs can be so diverse, being familiar with them and recognizing potential trauma is essential for providing services to people.

How Trauma Affects the Brain

The human brain develops as we age. This development varies somewhat from one person to the next, and the experiences we have, especially as children, can influence the development of our brains. During childhood, the brain matures, and a set of common capabilities develop in sequence for most people. For example, unless developmental disability or injury prevents it, we crawl before we walk, we babble before we talk, becoming more capable both through experience and through development. Toxic stress can derail healthy development, however, and early childhood trauma can have a significant impact across the person's lifespan.

Brain Development

The development of the brain during infancy and childhood follows a bottom-up pattern. The bottom-most regions of the brain develop first, and they are responsible for various essential regulatory functions within the body. This is followed by development in adjacent regions higher in the brain, with more complex responsibilities, such as cognitive and social functions. Much of this occurs during early childhood. The brain develops and modifies itself in response to experiences throughout this time.

Interaction and Brain Development

The different parts of the brain develop as a result of interaction with different people in our environment. The brainstem at the bottom of the brain controls blood pressure, body temperature, heart rate and arousal states, it is most effected by interactions between a child and their mother. The diencephalon is responsible for motor regulation, affect regulation, hunger and sleep, it's effected by interactions between the child and their caregivers. As we begin to move higher up the brain's structure the limbic system derives affiliation, attachment, sexual behavior and emotional reactivity, it's effected by interactions with family and friends. The neocortex making up the greater part of our brains is responsible for abstract and concrete thinking, it develops last and across a more extended period. The development of the neocortex is effected by interactions with peers, teachers and the community.

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Bottom-Up Reaction to Fear

With trauma, we have what we call "the bottom-up reaction to fear”. The fire alarm of the brain is located in the amygdala. It sounds the alarm about a threat and activates the fear response. The frontal lobes of the cortex, at the top, or the thinking, part of the brain, shut down to make sure the person is focusing entirely on survival. That's why it is so hard to think when you are in a crisis. At the same time, the ability to perceive new stimuli decreases, and the focus is on information and processes to ensure survival. The area of the brain responsible for speech, called Broca's area, shuts down as well. In our work, we often approach people in distress, asking them to tell us what is wrong. We ask them to stop and think or tell us how we can help. Access to the thinking resources of the brain may not even be possible in these moments. So, when people talk about "speechless terror" or "being scared speechless," this is not merely metaphorical, they are describing a real response of the brain. This has important implications for how each of us responds to crises, and for understanding people who are responding to the present through the lenses of their pasts. If we ask people in this state to "tell us what's going on," they may not be able to do it. At that moment, they may not have the words to use. Remembering trauma can reactivate the original trauma response. When a person recalls a traumatic event, often the fear response is activated, just like it was when the incident occurred. From the brain's perspective, it's like the threat is actually happening again.

Problems or Adaptations?

The fight, flight, or freeze responses are activated by danger. Some common behaviors of trauma survivors, behaviors that are often labeled as problems by the mental health system, can be directly linked to these responses and to the effects that trauma has on the brain. In the mental health system, anyone who struggles too hard to hold onto personal power may be labeled as non-compliant or combative. However, these behaviors are often the result of a fight reaction in the brain. This may be the person's response to trauma in the moment. Next, we can consider the flight response. In the mental health system, anyone who emotionally withdraws or disengages too much may be labeled as treatment-resistant or uncooperative. The third is the freeze response. In the mental health system, anyone who gives in too quickly to authority may be labeled as passive or unmotivated. Many of the people we serve have survived circumstances we can hardly imagine. What we often label as pathological may be the very things that helped them to survive. When we take a trauma-informed approach, we recognize symptoms and problem behaviors as adaptations to trauma.

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Factors Increasing Impact

The younger a person is when trauma occurs, the more likely they are to experience its consequences. Shame and humiliation are core features of the trauma experience for many people. These emotions can be devastating and impede healing. One of the most important messages you can give a trauma survivor is that no matter what happened, it wasn't their fault in any way. Sometimes trauma survivors are intimidated by their perpetrators into not telling what happened. Other times when they do try to talk about what happened to them, they are ignored or disbelieved. One of the most important things you can do for trauma survivors is to give them the chance to tell their stories. Healing starts when a person's personal experience is heard and validated. The impact of trauma is magnified when the perpetrator is a trusted figure, a relative, religious leader, coach, teacher, or therapist. This kind of trauma is often called betrayal trauma because the sense of betrayal can be so profound.

The Impacts of Childhood Trauma

Childhood traumas can occur from various sources. They can be blatant or subtle depending on the person, supports, and the environment. For instance, the author of this class is an army brat. Her family moved every year of her life until she was 18 years old. Living in various locations was exciting, and her family all moved together. Nonetheless, it did create trauma. Leaving friends, having to create new ones. Leaving schools, having to be accepted in a new one. Moving to foreign countries. Wondering, will there be people who can speak her language? Will people like her? Will she fit in? All these things create long-lasting impressions on a child. These insecurities carry over into adult life as part of who the person has learned to become. How they handle daily stressors is now part of the person.

Prevalence of Trauma in Children

A high percentage of children are exposed to potentially traumatizing events regularly, and approximately 71% of children are exposed to violence each year. Understanding how common these experiences are both validates them and tells us how critical trauma-informed practices are. Studies have found that roughly three million children in the United States are neglected each year. They say that significant amounts of children experience sexual abuse and that a majority of children are bullied at some point. These statistics are so high that many social service settings assume that every child they see may have had some form of trauma in their background.

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Adverse Childhood Experiences

The Adverse Childhood Experience Study, or ACE for short, is a pivotal series of risk studies that established the relationship between trauma exposure and physical health. The study was organized by the CDC and Kaiser Permanente in San Diego, California. Researchers surveyed more than 17,000 insured individuals from 1995 to 1997 about their experience of childhood trauma.

The ACE Study developed the ACE Score, which is a count of the total number of tracked experiences respondents reported. This score can be used to assess the total amount of stress during childhood. The initial study had some significant findings, including that: Childhood abuse, neglect, and exposure to other traumatic stressors, ACEs, are common. Almost 2/3 of study participants reported at least one ACE, and more than one in five reported three or more ACEs. The short and long-term outcomes of these childhood exposures include a multitude of health and social problems. As the number of ACEs increases, the risk for the various health problems increases in a strong and graded fashion, and with that, a direct, negative impact on mortality and longevity.

ACE: Across the Lifespan

Adopting risky behaviors can be a coping response to trauma, such as drinking alcohol to manage flashbacks. In a 1998 paper, Felitti and their colleagues asked: "Is drug abuse self-destructive, or is it a desperate attempt at self-healing, albeit while accepting a significant future risk?"

The adoption of risky behavior can put the person at greater risk and perpetuate the cycle of trauma and adversely affect their physical health and mortality. Research has shown a connection between adverse childhood experiences, or potentially traumatic experiences a person had before age 18, and health risk later in life. Although the mechanisms are not fully understood, researchers can trace the correlation between ACEs and a higher risk of social, emotional, and cognitive impairment. In turn, this can lead to a higher risk of adopting risky behaviors, which causes a higher risk of disease and early death.

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Prevalence of Trauma in Adults

Most people have some experience of trauma in their life. Many can cope and move forward. Others are more significantly impacted or may have a pre-existing disability that complicates their ability to move forward. Over 84% of adults receiving mental health services report trauma histories. People with disabilities have a high likelihood of being abused, and many people with substance abuse disorders report childhood abuse. One study found that a shocking have severe trauma histories. In the services we provide, significant trauma histories are prevalent. Some people require additional assistance to watch for triggers, to change environments, or to adapt to their situations. Establishing trust and encouraging the ability to identify harmful conditions can assist people in moving ahead.

Impacts of Trauma

As we discussed earlier, initial reactions to trauma can include exhaustion, confusion, sadness, anxiety, agitation, numbness, dissociation, confusion, physical arousal, and appearing emotionless. Most responses are normal in that they affect most survivors and are socially acceptable, psychologically effective, and self-limited. Still, some responses fall outside of these ranges. These responses are valid as well and they may be the only defense mechanisms a person has available to them. Trauma can also affect how you feel about yourself and how you relate to others. Individuals who have experienced extreme stress or have gone through abuse or other trauma have a higher risk of developing a mental health condition, such as depression, anxiety, substance use disorders, or post-traumatic stress disorder. Trauma can create long-term impacts for the rest of a person's life, especially if it goes unaddressed. Trauma and abuse are never your fault, and they are never the fault of the people we serve.

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Section Two: Principles of Trauma-Informed Care

Culture Change: The Four Rs

What may seem like inappropriate or unexpected behaviors in children and adults with significant disabilities are usually rooted in their experiences. Trauma-informed approaches take into account how an individual's past experiences can affect their reactions and perceptions now. Trauma-informed approaches reflect a fundamental shift in the culture of an entire organization. The four Rs highlight fundamental aspects of culture change that an organization must demonstrate as it becomes trauma-informed. The Four Rs reflect that it is not enough to simply know about trauma. Instead, to be trauma-informed, we must realize the widespread impact of trauma and potential paths for recovery. We must recognize the signs and symptoms of trauma in the people we support. We must reason by integrating knowledge about trauma into our policies, procedures, and practices. And we must seek to resist practices which may re-traumatize people actively. Trauma-Informed approaches can be implemented anywhere by anyone. Everyone in the organization has a role to play in becoming trauma-informed.

SAMHSA Principles

The Substance Abuse and Mental Health Services Administration, or SAMHSA, is a branch of the U.S. Department of Health and Human Services tasked with improving services for mental health treatment. The organization's six principles for trauma-informed approaches and culture emerged from a year-long process involving trauma survivors, family members, practitioners, researchers, and policymakers. During a public comment period, thousands of individuals wrote in with feedback on the definitions and overall approach. The goal was to develop a common language and framework.

The principles are value-based. Unlike manualized models for specific treatment interventions, these principles can be applied in a wide variety of settings, in many different ways, using whatever resources are available. As more agencies and organizations work to become trauma-informed, and as more and more claim to be trauma-informed, there needs to be a standard approach to assessing the progress organizations make toward being more trauma-informed. Implementing a trauma-informed approach requires constant attention and care, it's not about learning a particular technique or checking things off a checklist. Think about something as basic as respect or compassion. Can you do it at once, implementing a policy, and then check it off as done? Trauma-informed approaches are about a way of being, not a specific set of actions or implementation steps.

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Six Key Principles

The six key principles defined by SAMHSA include safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, and cultural, historical and gender issues.

1. Safety

Many of these principles, like safety, sound so simple and evident that you might wonder why we need to highlight them. Of course, we want everyone to be safe. Safety is a surprisingly volatile issue for staff as well as people served however. Safety means that throughout the organization staff and the people they serve feel physically safe, feel psychologically safe, have interpersonal interactions that promote a sense of safety. Often physical safety is a concern, especially for people who work at night and have to walk into dark parking lots or who work in rough neighborhoods. Incidence of workplace violence can have a ripple effect far beyond the specific circumstances. Staff may fear that their jobs are in jeopardy due to budget cutbacks, or they may be terrorized by workplace bullying. While these issues can not be resolved in this course, getting people to identify their safety concerns is an essential first step.

Example: Who Defines Safety?

But if we go below the surface a more complicated reality emerges. In one example, Laura Prescott a trauma survivor and advocate went on the wards of a Psychiatric Hospital, she asked both patients and staff what it was that made them feel safe. What she found was very interesting. Point for point staff and patients defined safety in almost completely opposite terms. In fact, it turned out that the very things that staff were doing to make the ward safer were making the patients feel less safe. So, what can you do in a situation like this?

First, just recognizing that safety may look different depending on your role and situation or your personal history is an important first step. The best thing you can do is to ask each individual what makes them feel safe and unsafe. This may mean rethinking policies and practices to attend to what both survivors and staff mean by safety. For example, rethinking use of seclusion and restraint, use of locked and unlocked spaces, tone of interactions.

2. Trustworthiness and Transparency

One of the most powerful ways of building trust is to give people full and accurate information. Just telling people what’s going on and what’s likely to happen next can be very important.

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Being clear is essential. Telling people they have more control than they really do will eventually destroy trust. For example, calling a program "peer-run" when in fact key decisions are made by the host organization is not trustworthy. Much better to explain what decisions are made by peers and what decisions are not.

Similarly, you may be required by your organization to break confidentiality when someone talks about wanting to hurt themselves. It is better to tell the individual upfront than to assure them of confidentiality and then break that trust.

Sharing your reactions and responses truthfully—being authentic—is also essential. Trauma survivors often have finely tuned "RADAR" to detect other people's emotional states—they have had to develop this capacity, a form of vigilance, to protect themselves. If you are untruthful about your feelings—even if you are trying to protect the other person—they are likely to detect it, and trust goes out the window.

Example: Emotional Transparency

Being emotionally transparent is a way of being truly honest about you. It just means sharing what comes up in you that prevents closeness in a relationship with peers and people you support. It could be fear, anger, sadness, resentment. A culture of internal transparency within a department or agency does not come about overnight. There can be many barriers, some of which can be quite complex. For example, employees may be reluctant to report safety issues or errors for fear of being reprimanded by their managers or shunned by their colleagues — even when we know that we are mandated to report such issues.

3. Peer Support

In this context, the term "peer" refers to individuals with lived experiences of trauma. Peer support is not a "service model"—it is about developing authentic mutual relationships, not applying a cookie-cutter approach to everyone. Peer supporters don't use clinical language or focus on what's "wrong" with people. Peer support doesn't offer top-down "helping" that disempowers people by taking away choice and voice. It is not "Peer Counseling," which implies that one person knows more than the other—peer support is about power-sharing. Peer support is a voluntary and non-judgmental approach to ensuring that the person has support organically, and in the context of their world. Mutual respect and reciprocal support is essential for successful peer supports, and, even beyond respect, shared empathy can solidify this relationship.

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The heart of peer support involves building trust. That isn't possible if people feel that peer support staff are acting as proxies for clinicians, case managers, or administrators, or are reporting on people's behavior. Trauma-informed peer support is not just important for people who receive services. It is important that staff who are trauma survivors have access to peer support, too.

Example: Building Trust

If a person you work with is experiencing a problem, you may need to intervene or gain their trust so they can feel comfortable talking with you. Knocking on a person's door, asking their permission to enter, asking for permission to discuss a situation can make one comfortable in expressing their feelings. Sometimes, it's important to acknowledge and allow the person to know you are there for them when they need. Asking for permission to sit in the room with them, or stating you are available to them privately IF they would like to talk or even sit quietly.

4. Collaboration and Mutuality

The principle of collaboration and mutuality includes practices like sharing of power with individuals and families. Leveling of power differences between staff and the people you provide support to, can create a safer environment where people feel both invested and valued. This approach recognizes that healing happens in relationships, and through meaningful sharing of power and decision-making. Everyone has a role to play in trauma-informed approaches, one does not have to be a therapist to be therapeutic.

Example: Developing Understanding

While working with individuals, listen to the people who know them best. First and foremost, listen to the individual, then look to other people in their life who can help. It could be a sister, a support-worker, or even a peer at work. The individual and people with intimate understanding of the person, especially those outside of the clinical context, can assist you to understand them the best. Be open to any and all collaborations.

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5. Empowerment, Voice, and Choice

This principle is one of the most powerful tools for organizational change. While it has become almost cliché to talk about recognizing people's strengths, it requires us to turn our thinking and actions around – to identify what people are doing right and build on their capacities rather than focusing on what's wrong with them. This may seem counterintuitive to some staff, particularly clinicians who may (rightfully) state that people should come to them with problems. Sometimes the best way to solve a problem is not by focusing on it, but by strengthening an alternative response. This way, the problem may eventually go away by itself. By building up an individual's ability to make their own choices, they become more adept at making better choices and they become more resilient. Self-advocacy and self-empowerment can make a difference in how much support a person needs, how much control they have over their own life, and how well they can protect themselves from potentially traumatic circumstances.

Often, it is our instinct as professionals to agree with these concepts in the classroom, but struggle to implement them in practice. The day-to-day demands of our work may lead us to set aside these values of voice and choice, but by doing so, we risk preventing the people we support from becoming more independent.

Example: Empowering Individuals

Organizations understand the importance of power differentials and ways in which individuals, historically, have been diminished in voice and choice and are often recipients of coercive treatment. Individuals are supported in shared decision-making, choice, and goal setting to determine the plan of action they need to heal and move forward. They are supported in cultivating self-advocacy skills. Staff are facilitators of recovery rather than controllers of recovery. Give people real choices, not "do you want to wear the red or blue shirt?" But more of "what can you tell me you would chose to wear today so I can assist you better?"

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6. Cultural, Historical, and Gender Issues

Trauma is context specific. That's why the first of the "Three Es" is "event." Women and men often experience different kinds of traumatic events, so gender-responsiveness is important in trauma work. The "experience" of trauma – the second "E" – depends on how the person understands what happened to them, the meaning ascribed to the event – which is heavily influenced by culture and history. Approaches that treat all people as being the same sound fair, but they don't truly acknowledge the important experiences we all have based on who we are and where we come from. Stereotypes and bias can hold us back at the same time, however, so we must all grow past harmful conceptions of our self and of others.

Example: Culture as Context

Cultural systems shape how people experience different illnesses and conditions, and how they respond to it. The ways that people understand and express their experiences is molded by this important context.

For example: Eye contact, body language, and facial expressions are basic examples of culture which you might not even think about on a regular basis. In some cultures, eye contact is a sign of respect and honesty, while in others it is a sign of challenge or assertiveness. Something as simple as looking a person in the eye could make them feel threatened or disrespected if you don't understand their cultural context. The better we understand these contexts, the less likely we are to cause trauma.

Principles Conclusion

There are many principles that one must consider when observing trauma and its effects. These are not simple or straightforward values to adhere to and require mindfulness and examination on an ongoing basis.

It is important to remember: Implementing a trauma-informed approach requires constant attention and caring; it's not about learning a particular technique or checking things off a checklist. Trauma-informed approaches are about a way of being, not a specific set of actions or implementation steps. Know the individuals you work with, support, live with in order to be the most effective advocate and friend.

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Section Three: Guidance for Implementation

From Goals to Approaches

Now that we've discussed the six principles, we can look at the ten domains identified by SAMHSA. If the six principles can be viewed as goals for trauma-informed care, the ten domains represent organizational approaches to achieve those goals.

SAMHSA: Ten Domains

Developing a trauma-informed approach requires change at multiple levels of an organization and systematic alignment with the six key principles we've discussed. The guidance provided here builds upon the key principles. It provides a starting point for developing an organizational trauma-informed approach. We recognize that not all public institutions and service sectors attend to trauma as an aspect of how they conduct business. However, understanding the role of trauma and a trauma-informed approach may help them meet their goals and objectives.

Organizations are encouraged to examine how a trauma-informed approach will benefit all stakeholders; to conduct a trauma-informed organizational assessment and change process; and to involve Individuals and staff at all levels in the organizational development process.

Governance and Leadership

Questions you might ask about Governance and Leadership include: How does agency leadership communicate its support and guidance for implementing a trauma-informed approach? Do the agency's mission statement and written policies support trauma-informed services? And How do leadership and governance structures demonstrate support for the voice and participation of the people served?

The leadership and governance of the organization need to support and invest in implementing and sustaining a trauma-informed approach. There should also be an identified point of responsibility within the organization to lead and oversee this work. A champion of this approach is often needed to initiate a system change process.

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Policy

Questions you might ask regarding Policy include: Do the policies and procedures include a focus on trauma and issues of safety and confidentiality? Do they recognize the pervasiveness of trauma in the lives of those your organization serve? Do they commit to reducing re-traumatization and promoting well-being and recovery? Do they demonstrate a commitment to developing staff via training and other supports so the care they provide is trauma-informed and reflective of the cultures of the people served? In considering this, note that supporting people with significant trauma can take a toll on staff if they are not well-supported. Finally, what policies and procedures are in place for including the people served in meaningful and significant roles in planning, governance, policy making, and evaluation for the agency?

In an organization demonstrating trauma-informed practices, written policies and protocols are establish a trauma-informed approach as an essential part of their mission. Organizational procedures and cross-agency protocols, including working with community-based agencies, reflect trauma-informed principles. This approach must be "hard-wired" into practices and procedures of the organization, not solely relying on training workshops or a well-intentioned leader.

Physical Environment

Questions you might ask related to Physical Environment include: How does the physical environment promote a sense of safety, calm, and de-escalation for individuals and staff? In what ways do staff members recognize and address aspects of the physical environment that may be re-traumatizing? How do staff work with people on developing strategies to deal with potentially re-traumatizing aspects of the environment? How has the agency provided space that both staff and people served can use to practice self-care? How have they developed mechanisms to address gender-related physical and emotional safety concerns?

In a trauma-informed organization, the agency ensures that the physical environment promotes a sense of safety and collaboration. Staff working in the organization and individuals being served must experience the setting as safe, inviting, and not a risk to their physical or psychological safety. The physical setting also supports the collaborative aspect of a trauma-informed approach through openness, transparency, and shared spaces.

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Engagement and Involvement

Questions you might ask about Engagement and Involvement include: What opportunities do people with experience receiving services have to provide feedback to the organization to improve services? How do staff members keep people fully informed about rules, procedures, activities, and schedules, while being mindful that people who are frightened or overwhelmed may have difficulty processing information? How are transparency and trust promoted? What strategies are used to make people served feel like equals with staff? How do staff members support people to identify their own strategies for feeling comfortable and empowered?

People with lived experience have significant involvement, voice, and meaningful choice at all levels and in all areas of organizational functioning — For example: Program design, implementation, service delivery, quality assurance, cultural competence, access to trauma-informed peer support, workforce development, and evaluation. This is a key value and aspect of a trauma-informed approach that differentiates it from the usual approaches to services and care.

Cross-Sector Collaboration

Questions you might ask about Cross-Sector Collaboration include: Is there a system of communication in place with partner agencies who also serve the same people? Are collaborative partners trauma-informed? How does the organization identify community providers and referral agencies that deliver trauma-informed services for the people served? What mechanisms are in place to promote cross-sector training on trauma and trauma-informed approaches?

Collaboration across sectors is built on a shared understanding of trauma and principles of a trauma-informed approach. While a trauma focus may not be the stated mission of various service sectors, understanding how awareness of trauma can help or hinder achievement of an organization’s mission is a critical. People with significant trauma histories often present with complex needs, crossing various service sectors. Even if a mental health clinician is trauma-informed, a referral to a trauma-insensitive program could then undermine the progress of the individual.

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Screening, Assessment, and Treatment

Questions you might ask about Screening, Assessment, and Treatment include: Is an individual's definition of emotional safety included in treatment plans? Is timely trauma-informed screening and assessment available and accessible to individuals receiving services? Does the organization have the capacity to provide trauma-specific treatment or refer to appropriate trauma-specific services? How are peer supports integrated into the delivery of services? How are gender-based needs and services addressed? Do staff members support people in understanding their trauma to minimize shame and fear?

Trauma-informed approaches are different from “trauma-specific interventions”—specific treatment modalities designed to address the behavioral health consequences of trauma. Both are essential.

Training and Workforce Development

Questions you might ask about Training and Workforce Development include: How does the agency support training and development for all staff regarding trauma and trauma-informed interventions? How does training address the aspects of identity, culture, community, and oppression which are important for informing understanding of trauma? What strategies are in place to assist staff in promoting peer supports among the people served?

Ongoing training on trauma and peer-support are essential. The organization's human resource system should incorporate trauma-informed principles in hiring, supervision, staff evaluation. Procedures can be put in place to support staff with trauma histories, and those experiencing significant secondary traumatic stress — also called vicarious trauma — resulting from exposure to and working with individuals with complex trauma.

Progress Monitoring and Quality Assurance

Questions you might ask about Progress Monitoring and Quality Assurance include: Is there a system in place to monitor progress in being trauma-informed? Does the agency solicit feedback from staff and individuals served? Does it assess staff feelings of safety and value at work? How do operations support quality improvement and attention to culture and trauma? What mechanisms are in place for collecting data for quality assurance, and how do they address creating trauma-informed supports? In an effective trauma-informed organization, there is ongoing assessment, tracking, and monitoring of trauma-informed principles and effective use of evidence-based trauma-specific screening, assessments, and treatment.

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Financing

Questions you might ask about Financing include: Does the budget include funding for the necessary training and development related to trauma at all levels of the organization? Does the budget include funding to support peer specialist development? Does the budget support maintaining a safe environment?

In a resilient and trauma-informed organization, financing structures are designed to support a trauma-informed approach which includes resources for: Staff training on trauma, key principles of a trauma-informed approach; Development of appropriate and safe facilities; Establishment of peer-support; Provision of evidence-supported trauma screening, assessment, treatment, and recovery supports; and Development of trauma-informed cross-agency collaborations.

Evaluation

Questions you might ask about Evaluation include: How does the agency measure the level and efficacy of their trauma-informed approach? How does the experience of people served inform agency performance and goals beyond consumer satisfaction surveys? What processes are in place to solicit anonymous and confidential feedback from people served?

In an evolving trauma-informed organization, measures and evaluation designs are used to evaluate service or program implementation, and effectiveness reflect an understanding of trauma and appropriate trauma-oriented research instruments.

Ten Domain Conclusion

The guidance for implementing a trauma-informed approach has been presented in the ten domains described in this section. Again, remember; this is not provided as a “checklist” or a prescriptive step-by-step process but are a good framework for reflecting on your organization.

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Definition of Recovery

As we close out this training, it is vital to make sure that we have a shared definition of recovery – a shared goal to work toward for the people we serve.

“Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”

Recovery is not a single state of being, it is ongoing, it is a process.

Conclusion

Thank you for attending this training on Trauma-Informed Care and its importance for individuals and for organizations. As you return to your work, think about these concepts and ask yourself: How can I develop as a trauma-informed provider? How can we improve as a trauma-informed organization?

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