

Being Trauma Informed and Responsive

A Training Toolkit

Key Concepts, Resources, and Recommendations

Introduction

The ACE Study (Felitti & Anda, 1997) and subsequent research has generated a growing awareness that trauma is frequently at the root of social, emotional, and psychological difficulties. Consequently, many individuals, systems and institutions across various human service sectors are seeking and/or providing training in trauma-informed service delivery. This section aims to draw on existing literature and resources, as well as the experience and expertise of individuals involved in this project, to provide an overview of trauma and its impact on youth.

Existing Models

Following is a brief discussion of existing models or frameworks that support the concepts discussed in this training. It is recommended that individuals who seek to provide trauma trainings or those who wish to engage in training to enhance their own trauma sensitivity or to build their competencies, delve deeper into these resources as well as those provided in the reference section.

Dr. Sandra Bloom (The Sanctuary Model, 1994) suggests that being “trauma-informed” means that one embraces and demonstrates new mental models informed by trauma theory. The way trauma-informed individuals and organizations think about behavior, violence, emotion, learning, communication, and growth is deeply impacted by their awareness of the prevalence and pervasiveness of trauma. The authors of this training, highly recommend the extensive works of Dr. Bloom and the Sanctuary Institute, especially in organizations and systems that seek a theory-based, trauma-informed approach to culture change.

Roger D. Fallot, Ph.D & Maxine Harris, PhD. (2009) offer an important overview of the rationale for trauma-informed service approaches, as well as a vision and guide for the change process necessary to shift frameworks and implement a trauma-informed approach. The rationale and vision for change are reflected in the concepts discussed in this training.

Additionally, Howard Bath (2008) provides three critical treatment elements for all individuals who interact with traumatized children as a part of their familial or professional roles. These “Three Pillars” include Safety, Connections, and Managing Emotions and align closely with the recommendations provided in the training.

Lastly, the Missouri Model (2014) provides an organized framework for considering the stages required in the process of becoming trauma-informed, as well as the knowledge, attitudes and skills that deepen as an individual, organization, or system progresses through the change process. It further provides a comprehensive list of resources that support growth. It should be noted that the training recommendations provided here align with the first stage in The Missouri Model's progression, "Trauma Aware," with the goal of movement toward more "Trauma Sensitive" approaches.

The key concepts described below draw on these and other resources, and provide the building blocks for training that aims to raise awareness about the prevalence and impact of trauma, and inspires changes in mental models, or framework shifts, that lead to more compassionate and supportive care for trauma-affected individuals.

Slide 2-Establish the Training Environment

Trauma, by its very nature, is a difficult topic that frequently inspires emotional reactivity. It is not uncommon for individuals to be deeply impacted by newfound knowledge related to the pervasiveness or impact of trauma, or by related discussions. Because of this high potential for reactivity among participants, it is proposed that the following parameters related to the learning environment within which a training be delivered in order to encourage safety, emotion regulation and support be considered.

Part 1

Trauma & Sensory Processing 101

It is recommended that youth serving professionals have an understanding of trauma and its impact on young people's health (physical and mental, including brain development) and behavior and success in school and their community.

Learning Objectives

By the end of this segment participants will be able to:

- Define trauma, its characteristics and prevalence
- Discuss the potential impacts of trauma on the developing brain and sensory processing
- Discuss long term physical and mental health impacts of trauma

Slide 5 & 6-Defining Trauma

SAMHSA defines **trauma** by discussing "Three E's," which include:

- an **event**, series of events, or set of circumstances
- that is **experienced** by an individual as physically or emotionally harmful or threatening, and
- that has lasting adverse **effects** on the individual's functioning and physical, social, emotional, or spiritual well-being.

Participants should have the following basic understandings:

- Trauma is not an event, in and of itself. For an event to be considered traumatic it must involve the individual's perception of the event as severely physically or emotionally threatening, and must impair the individual's functioning. For example, being placed in foster care is only a trauma if the child perceives the disrupted attachment to be overwhelming and frightening. Some children, albeit few, experience great relief when placed in a calm, nurturing foster home, and consequently would not experience the foster care placement as traumatic.
- Trauma is complex and manifests in unique ways in each person impacted.
- Trauma, especially chronic or complex trauma of an interpersonal nature is frequently under-reported and under-diagnosed.

Slides 7-9-The Impact of Adverse Childhood Experiences and Implications for Adulthood

The original Adverse Childhood Experiences (ACE) study was conducted in 1997 by Robert Anda, MD, MS from the CDC and Vincent Felitti, MD from Kaiser Permanente in California. The survey included 10 types of adverse experiences –

- physical, sexual and emotional abuse;
- physical and emotional neglect;
- living with a parent/caregiver with a
 - mental illness,
 - substance abuse disorder,
 - or who was incarcerated;
- parents who were separated or divorced
- witnessing domestic violence.

Each type of adverse experience was counted once and the total number of experiences was called the ACE score.

There were 2 primary findings – ACEs are prevalent (see slide 8) and there was a strong correlation between the number of ACEs and a host of behavioral, emotional and physical outcomes (see slide 9). The findings are supported by a growing body of research in the fields of epidemiology, neuroscience, psychology and genetics. Slide 7 shows the mechanisms theorized as a result of the ACE study.

It is important to note that ACEs are not destiny. Even though the findings point to the important impact of childhood adversity later in life, many people experience trauma and are healthy, successful adults. The effects of trauma are mitigated by resilience often in the context of supportive relationships and/or intentional interventions.

Slide 10-Prevalence in Michigan

Michigan included the original 10 ACE questions in the 2013 Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is an annual survey of adults in Michigan. The results were similar to the findings in the original ACEs study. An expanded version of the ACEs questions and some resilience questions were incorporated in the 2016 version of the MI BRFSS. Data from that survey should be available in 2017. Additional information is available at www.michigan.gov/mdhhs/brfss. The National Survey of Children's Health is conducted by the National Center for Health Statistics at the Centers for Disease Control under the direction and sponsorship of the Maternal and Child Health Bureau. This is a telephone survey conducted periodically. The most recent results are from the 2011-12 survey. More information is available at <http://childhealthdata.org/learn/NSCH>.

Slides 11-13-Responses to Stress & Triggers

There are 3 primary responses to any stress – fight, flight or freeze. These responses are important strategies to keep us safe in the face of danger or potential harm. However, if we are repeatedly exposed to trauma or develop traumatic stress disorders those same responses may be triggered by events that are not necessarily dangerous but remind us of previous trauma. Children respond differently at different ages and those responses may resemble psychiatric disorders when, in fact, they are indicative of traumatic stress.

Slides 14-20-Trauma is a Sensory Experience

Traumatic events, including experiencing or witnessing violence, abuse, or neglect, often lead to substantial deficits in neurodevelopment, and produce symptoms of dysregulation, hyper-arousal, sensory sensitivity, avoidance, and dissociation in individuals. In particular, children with trauma histories demonstrate deficits in cognition, memory, sensory modulation, and visual processing (Ito, 1999; Koomar, 2009; Richardson, et al., 2015).

Slide 14 demonstrates, using a hand model, the activation of different areas of the brain (specifically the brain stem and limbic system) when faced with fear/danger.

Many children who have experienced trauma interpret sensory inputs from their environments differently and a large proportion experience sensory modulation disorders also known as sensory processing disorders (SPD) or Sensory Integration Dysfunction (Atchison, 2008). Sensory processing disorder can occur with other diagnoses including PTSD, autism, anxiety disorders and attention deficit disorders.

Sensory Processing (also commonly referred to as sensory integration) refers to the way in which the central nervous system receives input from the senses, organizes it and uses it to create appropriate motor and behavioral responses. Sensory Processing Disorder is a condition that occurs when the brain has difficulty detecting, registering, organizing, interpreting and responding to internal and external sensory information. In other words, the brain does not organize sensory information in a way that allows the child to get an accurate sense of himself or his world (Ayres, 1972).

Most of us are familiar with 5 sensory systems – vision, hearing, taste, smell and touch. There are 3 additional sensory systems – proprioception (feedback about joint positions that helps with posture, motor planning & control); vestibular (feedback about position of head, speed & direction of our movements) and interoception (internal sensors; feedback about internal organs and guide hunger, respiration, heart rate and elimination).

Children with sensory processing disorders are at higher risk for emotional, social and educational challenges. They are often labeled clumsy, uncooperative, lazy, belligerent, oppositional, disruptive, manipulative or “out of control.” Anxiety, depression, aggression or other behavior issues are more common in children with sensory processing challenges. Parents may be blamed for their behaviors and adults and peers can become frustrated with the child and ask “What’s wrong with you?” when the more productive question might be “What does the world FEEL like for you?” (Star Center Foundation, 2016)

Children who are **over-responsive** to sensory stimuli tend to respond too much, too soon or for too long to sensory stimuli that other children tolerate easily. These children may:

- Be sensitive to textures or tags in clothing and have a limited wardrobe
- Have a limited diet
- Be prone to fighting while waiting in line
- Be scared on stairs or elevators
- Get car or bus-sick often
- Become upset in loud or crowded places
- Startle easily to sound and/or cover his ears to sounds other children tolerate
- Be overly sensitive to the sun, florescent lighting or bright lighting
- Have difficulty with changes in routine, transitions and unpredictability

Children who are **sensory under-responsive** may:

- Be unaware of sensory input others notice
- Have a delay before responding to sensory input
- Have a high pain threshold, not cry when hurt
- Seem to not notice when his name is called
- Seem tired or lethargic
- Seem unaware of things around him
- Not notice noxious smells

- Need to watch his hands when using them
- Prefer sedentary v. active, physical play
- Appear passive, unmotivated or apathetic

Sensory seeking children may:

- Be fidgety
- Love rough and tumble play
- Be in “perpetual motion”
- Be hard to calm
- Be constantly touching or poking objects or peers
- Have difficulty sitting still
- Fall on purpose
- Stare at moving objects/reflections
- Appear to be a risk taker
- Chew or mouth non-food objects

Slide 21- Team Time

Take time to check in with yourself and with others at your table. What are your reactions to this information? Can you think of children/adults that you’ve worked with who have these behaviors?

Part II: Trauma & Sensory Related Strategies

Slide23-Part II Objectives

- Discuss keys for integrating trauma informed principles
- Describe strategies for responding to trauma-related behaviors
- Identify environmental strategies that support healing & resilience
- Discuss compassion fatigue and self-care strategies

Slides 24-31- Trauma Informed Services

“Trauma-informed care is an approach to engaging people with histories of trauma that recognize the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.” - **National Center for Trauma Informed Care** (NCTIC, www.samhsa.gov/nctic, 2013)

Falot and Harris (2009) provide the following definition of trauma-informed care: Human service systems become trauma- informed by thoroughly incorporating, in all aspects of service delivery, an understanding of the prevalence and impact of trauma and the complex paths to healing and recovery. Trauma- informed services are designed specifically to avoid retraumatizing those who come seeking assistance as well as staff working in service settings. These services seek “safety first” and commit themselves to “do no harm.”

Slide 29-Key Assumptions and Principles

SAMHSA developed a set of guidelines for a Trauma Informed Approach which identifies 4 key assumptions inherent to trauma informed services:

1. **Realize** the widespread impact of trauma and understands potential paths for recovery;
2. **Recognize** the signs and symptoms of trauma in youth, families, staff, and others involved with the system;
3. **Respond** by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seek to actively **resist** re-traumatization.

These assumptions can be operationalized by incorporating 6 key principles into any organization or system of care:

1. **Safety:** Ensure both physical & psychological safety for staff as well as youth/families.
2. **Collaboration:** Partner with youth/families and all staff to meaningfully share power and organizational decision-making.
3. **Voice & Choice:** Staff are facilitators rather than controllers of healing. Youth/families are supported in shared goal-setting and determining the plan of action. Self-advocacy skills are encouraged for youth/families and staff.
4. **Trustworthiness:** Organizational operations and decisions are conducted with transparency with the goal of building and maintain trust for all involved with the organization.
5. **Peer Support:** Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration and utilizing stories and lived experience to promote healing.
6. **Cultural, Historical, and Gender Issues:** Some people bear an extra burden of trauma based on belonging to a specific group(s). Incorporate policies, protocols and processes that are responsive to the racial, ethnic and cultural needs of the individuals served; and recognize and address historical trauma.

For more information see: SAMHSA, (2015) "The Concept of Trauma and Guidance for a Trauma Informed Approach", <http://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf>

Slides 32 & 33 How to Respond

A key element of trauma informed care is to change the focus from diagnosing illness or problems to understanding a person's history. Some organizations do this by screening for trauma which can be appropriate if providing treatment or making referrals for treatment is a service offered. For some organizations the focus may not be on screening or treatment but on understanding that trauma may be a factor in the youth's behaviors and then being prepared to respond to disclosures of trauma.

Slide 34- Team Time

Take some time to check in with yourself and others at your table. How are you reacting to this information? What are things you can do differently in your work with young people?

Slides 35-48-Strategies

This section provides strategies for addressing and assisting youth to heal from trauma. These strategies are not “one size fits all,” nor will any one strategy work all of the time. We suggest that you add them to your “tool kit,” remembering that your most important tools are your desire to understand and support the child and your keen observation skills.

Recall that (Slide 30)...

- SAFETY precedes learning
- FEAR overrides cognitive capacities
- BEHAVIORS communicate brain states
- ENVIRONMENT & ACTIVITIES can calm
- RELATIONSHIPS can heal
- NON-VERBALS are powerful
- TEAMWORK and shared responsibility are vital
- CONNECTIONS within the school and with community providers and systems are required

-Adapted from NCTSN: Child Trauma Toolkit for Educators (2008)

Slide 35-Strategies-Regulate, Relate, Reason (Perry, 2006)

Slides 36-42-Regulate

Regulate Checklist

- Understand the youth
- Understand yourself and manage your own reactions
- Recognize that the behavior is communicating internal affect or dysregulation
- Match emotion then guide toward calm
 - *Consider appropriate verbal responses*
 - *Limit questions*
 - *Call on practiced strategies/ exercises*
- Consider the Environment
- Create quiet/safe spaces
- Be aware of lighting and background noises
- Encourage respect for personal space
- Develop predictable routines
- Provide advance notice for transitions and changes of routines
- Create opportunities for organizing movement throughout the day
 - Sensory Strategies - Several slides have been provided that offer proactive and reactive strategies for youth who have sensory processing related challenges.

Slides 43-44-Relate

- The connection between traumatized youth and adults is essential to the healing process
- Regardless of the adversity faced, a positive attachment to adults will lead to more positive outcomes for children.
- The brains of traumatized children have learned to associate adults with negative emotions

Slide 45-Build Empathy among Faculty and Staff

- Recall that 1 in 4 youth have experienced significant adversity and MOST helpers have also experienced adversity.
- Survivors of trauma are typically not being purposefully stubborn or oppositional
- REFRAME: ***“What happened to you?”*** not, *“What’s wrong with you?”*
- REFRAME: ***“Symptoms” are adaptive coping*** necessary to survive, not as pathology
- REFRAME: ***“Behaviors” as communication*** that can lead to understanding
- PTSD symptoms are ***normal*** reactions to ***abnormal*** circumstances.
- The individual is a ***survivor***. Celebrate their survival mechanism(s)

Relational Checklist:

- How is the youth regulated?
- How am I regulated?
- Do I need to employ additional regulation strategies?
- Relate- consider:
 - Tone of voice and volume?
 - Youth’s relational needs?
 - Youth’s preferences for relating? What communication modes will support a relationship in this moment?
 - Youth’s references for relating? Being with? Doing with? Talking with?
 - Body language to support a relationship?
 - Positive communication (praise strategy use; acknowledge and encourage calm; connect)
 - Listen without trying to solve; Avoid trying to make it better

Slides 46-47-Reason

- Focus on Restorative Practices
- Punishment vs. Consequences
 - Consistency and Individualized Responses*
 - Developmental, TI Consequences*
 - Consider triggers and experiences
 - Retain youth in learning/services

- Consider function of behavior & encourage skill development
 - Help youth to recognize impact
 - Recognize that change is slow and incremental
- Focus on Relational Repairs
- Focus on Future strategies

Reason Checklist

- Am I regulated?
- Is the youth regulated?
- Is there a need for relational repair?/ What is the strength of our relationship?
- Has there been a sufficient/reasonable amount of time since the incident? Is this a reasonable time to engage in a dialogue with the youth?
- Do I have reasonable goals for this meeting?
- Does the youth have reasonable goals for this meeting?

Reason Strategies:

- Reframe negative behavior as growth opportunity
- Review strategies used and consider need for modified/new strategies- let youth drive
- Support autonomous decision-making and independent functioning
- Emphasize youth's ability to make changes
- Foster hope
- Celebrate healthy insights and change
- Provide pro-social opportunities and encourage restorative practices that involve community interaction and support

Slide 48-Environmental Strategies

Strategies for Trauma and Sensory Friendly Environments

- Routines/ consistency
- Choices
- Clear, firm limits for inappropriate behavior
- Sensitive to environmental cues that can trigger reactions
- Anticipate difficulties and provide additional supports
- Provide warnings
- Understand trauma re-enactment

Think of specific examples relevant to the audience

Slides 49-52-Coping with Compassion Fatigue (aka Secondary Exposure to Trauma)

Individuals who engage empathically in their professional or familial roles with people who have been impacted by trauma are vulnerable to emotional and psychological distress. Every trauma-focused training, regardless of duration and intensity of focus, should underscore the potential impact of this work on the caregiver, and provide supportive resources for helpers to monitor and address their own emotional needs. The term **Vicarious Trauma** (VT) (Perlman & Saakvitne, 1995), also called **Compassion Fatigue**, is the latest term that describes the phenomenon generally associated with the "cost of caring" for others (Figley, 1982).

Slide 51- The ABCs of Addressing Compassion Fatigue or Vicarious Trauma

Pearlman encourages the ABC approach to managing the risk for VT, which includes attending to the following domains: Awareness, Balance, and Connection. It is recommended that trainees utilize the ABCs of Managing Secondary Trauma worksheet, (<http://www.csom.org/train/trauma/documents/ABCs%20Handout.pdf>) and that they are encouraged to develop a plan to mitigate their own risk for VT.

Additionally, The University of Buffalo's School of Social Work provides a readily available "Self-Care Starter Kit" that assists individuals to develop self-care plans, provides assessments, and suggests various activities and exercises to encourage the emotional and physical health of caregivers. <https://socialwork.buffalo.edu/resources/self-care-starter-kit.html>
A useful and easy-to-use resource is the Emergency Self Care Worksheet, which is closely aligned with the Sanctuary Model's Safety Plan.

Slide 53- Organizational Strategies

Secondary trauma affects individuals but it can also affect organizations, leading to decreases in quality of services; staff turnover; a negative feedback loop among staff and increased costs for recruiting and training new staff. Organizations can work to prevent or reduce secondary traumatic stress by: promoting general wellness (e.g. sponsoring yoga, exercise or meditation classes); an organizational culture that promotes self-care, provides adequate health/mental health benefits, caseload management and allows "mental health" days; education about Secondary Traumatic Stress and self-care; and reflective supervision that allows providers to reflect on the impact their work has on them in a supportive relationship with the supervisor.

Slide 54- Next Steps

What do you and others from your team plan to begin when you return to your workplace to begin to become more trauma-informed in your practices?

References:

Part 1

1. The National Child Traumatic Stress Network website includes definitions for trauma and traumatic stress and the prevalence of childhood trauma along with many other resources. <http://nctsn.org>
2. Likewise SAMHSA provides a definition of trauma <http://store.samhsa.gov/shin/content/SMA14-4884.pdf>
3. For more information about the ACEs study
Centers for Disease Control <http://www.cdc.gov/violenceprevention/acestudy>
ACESTooHigh Website <http://acestoohigh.com/2012/10/03/the-adverse-childhood-experiences-study-the-largest-most-important-public-health-study-you-never-heard-of-began-in-an-obesity-clinic/>
4. Additional information about ACES in Michigan available at
<http://michigan.gov/mdhhs/mibrfss>
<http://childhealthdata.org/learnNSCH>

5. TEDtalk: How Childhood Trauma Affects Health Across a Lifetime: https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime?language=en
6. Atchison, B.J. (2007). Sensory Modulation Disorders among Children with a History of Trauma: a Frame of Reference for Speech-Language Pathologists. *Language, Speech, and Hearing Services in Schools* (38), 109116.
7. "Sensory Processing Disorder Resource Center", <http://www.sensory-processing-disorder.com/>
8. Video: Explaining the Brain to Children & Adolescents: <https://vimeo.com/109042767>

Part 2

1. Bath, H. (2008). The three pillars of trauma informed care. *Reclaiming Children and Youth* , 17-21.
Link: <https://s3-us-west-2.amazonaws.com/cxl/backup/prod/cxl/gklugiewicz/media/507188fa-30b7-8fd4-aa5f-ca6bb629a442.pdf>
2. Fallott, R.D. and Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning tool. Retrieved March 11, 2016, from Community Connections: <https://www.healthcare.uiowa.edu/icmh/documents/CCTICSelf-AssessmentandPlanningProtocol0709.pdf>
3. The Missouri Model- A Developmental Framework for Trauma Informed (2014) <http://dmh.mo.gov/trauma/MO%20Model%20Working%20Document%20February%202015.pdf>
4. SAMHSA, (2015) "The Concept of Trauma and Guidance for a Trauma Informed Approach", <http://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf>
5. Dr. Bruce Perry provides many resources to support learning about neurodevelopment. Many are available through the Child Trauma Academy (www.childtrauma.org).
6. MI Department of Health and Human Services (2016), "Becoming Trauma Informed: A Guide for Child Serving Organizations", www.michigan.gov/traumatoxicstress.
7. Lesley University and Trauma and Learning Policy Initiative, "Trauma-Sensitive School Checklist, www.lesley.edu/WorkArea/DownloadAsset.aspx?id=7894
8. OT-Innovations.com, Information about creating sensory rooms, <http://www.ot-innovations.com/clinical-practice/sensory-modulation/sensory-rooms-in-mental-health-3/>.
9. ABCs of Managing Secondary Trauma worksheet: <http://www.csom.org/train/trauma/documents/ABCs%20Handout.pdf>
10. Emergency Self Care Worksheet: <https://socialwork.buffalo.edu/content/dam/socialwork/home/self-carekit/Emergency%20Self-Care%20Worksheet%20NEW-2.6.15.pdf>

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