



Good Practice Briefing

Developing A Trauma Informed Approach
The importance and application of A Trauma Informed Approach for Working with Survivors of Gender Based Violence.

Contents

1. Defining Trauma
2. The Impact Of Trauma In The Brain
3. The Impact Of Trauma In The Brain
 - 3.i. The Neurobiology Of Trauma
 - 3.ii The Trauma Response
 - 3.iii. Flight, Fight, Freeze, Flop And Friend Survival Behaviours.
 - 3.iv. Trauma Pathway
4. Impact Of Trauma
 - 4.i. Clinical Conceptualisations Of The Impact Of Trauma
 - 4.ii. PTSD And Gendered Violence Statistics
5. Trauma Informed Approach
 - 5.i. Definition Of Trauma Informed Care
 - 5.ii. Key Principles Of Trauma-Informed Approaches
 - 5.iii Working Specifically With Survivors Of Gender Based Violence
6. The WGN Application Of TIA Within WGN 'Holistic Empowerment Recovery Model (HER)
8. Good Practice Guidelines For Engaging Clients And Embedding A TIA
9. Trauma Informed Guides And Screening Tools
10. Referances

Tables and Figures

Figure 1: Brain

Figure 2: Trauma Pathway

Table 1: Polyvagal Theory

Table 2. Global impact and sequela of symptoms

Table 3. Developmental Trauma, PTSD, CTS

Table 4: Trauma Informed vs Trauma Specific

Figure 3: WGN's Holistic Empowerment Recovery Model

Figure 4: Window of Tolerance

ASCENT – Support services to organisations

Ascent is a partnership within the London Violence Against Women and Girls (VAWG) Consortium, delivering a range of services for survivors of domestic and sexual violence, under six themes, funded by London Councils.

ASCENT – Support services to organisations, is delivered by a partnership led by the Women’s Resource Centre (WRC) and comprised of five further organisations: AVA, IMKAAN, RESPECT, Rights of Women, and Women and Girls Network.

This second tier support project aims to address the long term sustainability needs of organisations providing services to those affected by sexual and domestic violence on a pan-London basis. The project seeks to improve the quality of such services across London by providing a range of training and support, including:

- Accredited training
- Expert-led training
- Sustainability training
- Borough surgeries
- BME network
- One-to-one support
- Policy consultations
- Newsletter
- Good practice briefings

Good practice briefings

The purpose of the good practice briefings is to provide organisations supporting those affected by domestic and sexual violence with information to help them become more sustainable and contribute with making their work more effective.

For more information, please see:

www.thelondonvawgconsortium.org.uk



**London
VAWG
Consortium**

Women and Girls Network

Women and Girls Network (WGN) is a free, women-only service that supports women in London who have experienced violence, or are at risk of violence.

We offer counselling, advocacy and advice for women and girls who have experienced gendered violence, including sexual and domestic violence.

Our overall aim is to promote, preserve and restore the mental health and well-being of women and girls, to empower them to make a total and sustainable recovery from their experiences of violence.

Ascent services

Through the Ascent partnership, we offer free counselling for women in London who have experience of any form of gendered violence. To refer, call 020 7610 4678 or email ascentcounselling@wgn.org.uk. Check our website, www.wgn.org.uk, for information on which boroughs referrals are currently open for

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1. INTRODUCTION

In introducing this briefing paper it is fitting to offer a reflective point on the development and application of a 'Trauma Informed Approach' (TIA) within the services and counseling rooms of Women and Girls Network. The following briefing paper brings together over 30 years' experience of working with survivors of gendered violence. WGN has a unique 'herstory' in that our understanding of gendered violence as a traumatic experience has matured alongside the first connection that both sexual violence survivors and war veterans had similar experiences of P.T.S.D.

It is useful for readers to note that this is not a 'trauma informed toolkit'. Numerous toolkits are available for practitioners (See Reference List) which provide information on how to assess, evaluate, plan and implement ways in which to become trauma informed.

Our intention within this briefing paper is not to replicate such kits but to offer our unique application of trauma informed philosophy and principles that we endeavor to permeate within all connections and interactions we have with the women and girls who access our services.

Our offering within this briefing paper is an illustration of an organization that from its inception has rooted within it a T.I.A. due to its origin as a 'trauma specific service'. (See definition in section 5).

We offer, an overview of a trauma informed model that we have evaluated as good practice through the direct implementation with women and girls who in many instances experienced sustainable recovery from gender based violence.

Our approach combines the application of knowledge and understanding of trauma manifestations and adaptations to support the healing and recovery of individuals within a feminist strength based and recovery oriented practice framework.

2. DEFINING TRAUMA

The word 'trauma' is now a commonly used term in both personal and professional settings. In recent years, there has been a growing interest and body of evidence to explain the way in which humans experience and cope with trauma.

The word 'trauma' originates from the Greek word meaning a deep wound. Trauma is defined as a psychological, physical threat or assault to an individual, involving their physical integrity, sense of self, safety and survival.

Such an experience results in an overwhelming amount of stress for an individual that can exceed one's ability to cope or integrate the emotions involved with that experience.

Within this context the behaviours experienced under the umbrella of gender based violence are traumatic events. These include rape, sexual assault, sexual exploitation, gang related violence, bullying, domestic violence, harmful practices i.e. FGM/ forced marriage etc.

In addition, childhood abuse and neglect: experience of war and conflict; sudden loss of life; accidents; natural disasters as well as witnessing violence are deemed as traumatic experiences.

In further understanding trauma it is useful to consider the frequency and duration of the traumatic event(s). This is not to diminish any one of the following traumatic experiences as being more harmful than the other, however, as research¹ has shown that two individuals experiencing the same traumatic event can respond in two differing ways. As practitioners within the field of gendered violence, it is important to consider the nature and duration of the event, in order to understand the potential impact and trauma symptoms that maybe present.

Therefore, it is useful to explore :- is it a single incident (rape, FGM); complex or repetitive (domestic violence; coercive control) and/ or experienced during the developmental years of child hood (gang related violence, child sexual exploitation). Additionally, in working within an intersectional lens it useful to consider any historical events such as: colonization, (disconnecting cultures from cultural practices), genocide, slavery, inequality, persecution and criminalisation of groups and practices, in order to understand how all these contributing factors offer the unique trauma imprint on the individual being supported.

3. THE IMPACT OF TRAUMA IN THE BRAIN

3.i. The neurobiology of trauma

The human brain is a complex system and is divided in terms of structure and function through the process of evolution into three distinct parts. The oldest and most primitive part of the brain, the brain stem, is referred to as the reptilian brain and is concerned with internal hemostasis such as breathing and heart rate etc.²

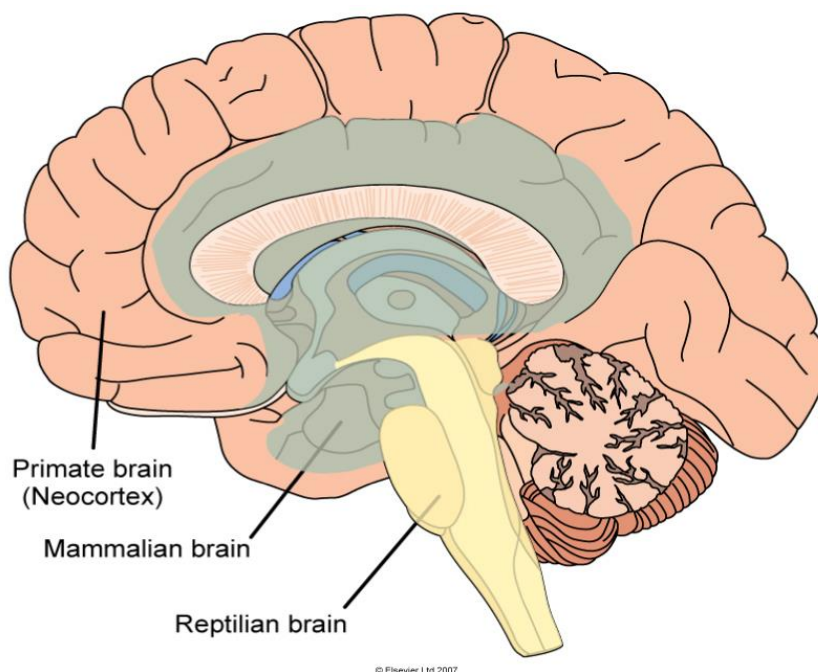
¹ Levine. P. (1997): *Walking the Tiger Healing Trauma*

² Van der Kolk, B. (1996): *Trauma and Memory. Traumatic Stress: The effects of overwhelming experience on mind, body and society.*

The mammalian brain (the limbic system) is responsible for basic instincts towards; safety, food, shelter, sex, power, attachments and emotional responses of anger, anxiety, sadness joy and lust. Fundamentally within the trauma response it is the limbic system that governs the survival reactions of fight, flight, freeze, flop and friend. The processing systems within the limbic system are fast, involuntary and hard to verbalize.

The cerebral cortex and frontal lobes of the higher human brain appeared as a genetic shift 2 million years ago and enabled analysis of the external world, self-awareness and consciousness, eternal understanding. This enabled the development of advanced skills such as: planning, the evaluation of consequences, imagination (mental imagery) and ruminations (ability to worry). The processing systems of the cortex are; integrated, evolved, slow, reflective, easy to verbalise. The system engages with cognitive competencies and the learning of social rules, opposite to the limbic system it is a slower more voluntary system. The cerebral cortex is divided into two interconnected lobes with differentiated function. The left hemisphere is concerned with linear thought, logic, analysis and language with functions closely aligned to cortical functioning. The right side of the brain relates to nonverbal more emotive and body sensation of the reptilian and mammalian brain.

Diagram 1: Brain



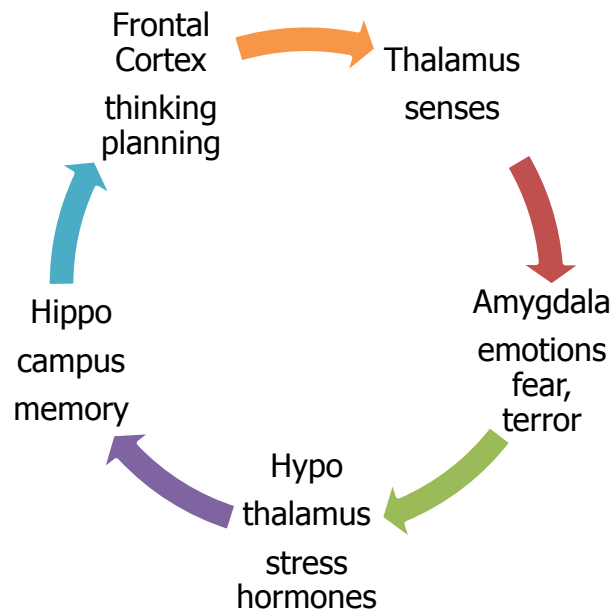
3.ii The trauma response

Danger and the fear response are located in the mammalian brain in a collection of primitive structures referred to as the limbic system. The thalamus is the central neural centre for all five senses (vision, hearing, smell, taste and touch). The amygdala is a small almond like structure and is associated with big emotions related to fear, horror, attachment and emotional/ sensory memory. The amygdala is activated by visual or auditory threat with an incredibly fast response rate, firing at 7 millionth of a second. Once the amygdala is activated it will fire the hypothalamus to release the stress hormones, cortisol and adrenaline, which prepare the body for flight and fight responses. The Hippocampus is linked to memory function and retains information in a spatial and chronological order, similar to the functions of a filing cabinet and filing system where everything is logically filed and everything is in its own space. Trauma material cannot usually be integrated into this system and tends to be repeated via a loop type memory system referred to as an active memory, responsible for flashbacks during the day and nightmares of a night. In usual neural functioning the frontal cortex will activate an appropriate response. However, in trauma situations terror and fear responses overwhelm brain functioning with survival mode superseding all other brain activities and inhibiting activation of the frontal cortex resulting in an impairment of executive functioning and the loss of the ability to plan, organise or take appropriate action.

3. iii. Flight, Fight, Freeze, Flop and Friend Survival behaviours.

Defensive survival behaviours referred to as the 5 F's dictate responses. The initial human instinct is flight, to run from danger, without an escape route but with strength a fight response is activated. In situations without either an escape route or strength, the body switches the nervous system response (from sympathetic to parasympathetic) triggering first catatonic immobility or a freeze response and then with repeated exposure to danger activating the opposite tonic immobility to a loss of muscle tension resulting in a flop response. An additional response available to humans within the defensive survival behaviours is the 'friend response'. This is considered to be our earliest defense strategy, similar to babies crying when in danger to alert others and bring a caregiver. With language individuals are able to negotiate, plead or bribe in an effort to overcome danger. The social engagement system can be heightened in extreme situations with adaptations and connections to the aggressor as seen in the Stockholm syndrome.

3.iv. Trauma pathway



4. Polyvagal Theory³

Traditionally the understanding of the autonomic nervous system was that it involved 2 states governed by the parasympathetic branch (the main pathway to calm, rest, digest, freeze, flop) and the sympathetic branch (supporting excitement, mobilization, fight or flight)

In recent years the work of Stephen Porges has revolutionized our understanding of the trauma response through his 'Polyvagal Theory'. Within the 'Polyvagal Theory', Porges has identified there being 3 states or options that the body has to determine safety through the autonomic nervous system. His theory concludes that the option of the additional state is due to the parasympathetic branch consisting of the 'old vagus' and the 'new vagus'. It is in fact the recognition and presence of the 'new vagus', which offers a deeper understanding of not only the trauma response but also how to become more trauma informed to support recovery.

³ Porges SW (2011). The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-regulation. New York: WW Norton.

Porges description of the trauma response is often described as a traffic light system. The following tables offer a comparative of the three states and the responses based on increasing threat and arousal.

Table: Polyvagal Theory

	Green	Amber	Red
Autonomic State	New Vagus (myelinated branch) Parasympathetic,	Sympathetic nervous system activated	Old Vagus (demyelinated) Parasympathetic
State Description	"I can"	"I have to"	"I can't"
State	- In this state we feel safe and well - Our social engagement system is on track,	In this state, as we get ready to flee if an escaper route exists. If one is not available then we get ready to fight the potential threat or danger,	In extreme situations, in the face of rising danger the body immobilizes, freezes and shuts down.
Physiological Changes	- Our heart rate slows down, - Saliva and digestion are stimulated, - Facial muscles are activated, - There is increased vocal prosody and eye contact, - Middle ear muscles are turned on – so you can better hear human voices,	- Non-essential systems are switched off and the blood goes to the big muscles in order to be prepared to run or fight. - Pain tolerance goes up, - Flat facial affect, - Feeling danger our audiology shifts, middle ear muscles turn off so we can better hear extreme low and high frequency sounds (predator sounds, screaming)	As the organism is overwhelmed the involuntary response of freeze and immobilization takes place. The state within which dissociation occurs.
Threat and arousal detected	If threat and arousal are detected, we begin to orient and seek safety the new vagus, begins to come off and we begin to check escape routes	As threat and arousal further increase we mobilise towards an escape route	Overwhelming threat and danger are experienced.

As organizations working with survivors of gendered violence, Porges' 'Polyvagal Theory' offers an understanding of the vagus as a key component in internal and social regulation in response to environmental challenges, stressors and threat. He offers us an insight into its role within emotion, attachment and social engagement. Fundamentally, he argues that for humans secure attachment is associated with an evolved increase in vagal tone (activity) in safe situations. Furthermore, his theory suggests that it is through 'social engagement' with a safe other that we are able to successfully co-regulate that in fact, as mammals, co-regulation is essential to our survival and therefore we seek opportunities to co-regulate as a way to self-regulate. For example, in a situation, where a child hears a loud bang, she will first look towards the primary carer to ascertain the level of threat, if the mother's system is showing no stress and is regulated the child will also co-regulate. Porges, states 'that our nervous systems crave social interactions that provide opportunities to co-regulate.' Therefore, when this social engagement and regulation system is in the green 'new vagus state' we are able to dampen and down regulate the stress response, including the adrenal circuits which release cortisol/adrenaline, which in turn means that the essential systems are more able to facilitate health, growth and restoration, all of which are cut off when the amber or red states are activated and hence the correlation between stress and poor health.

It is important to understand that healthy individuals can move between the two states of green to amber in safe environments. However, moving in and out of the red zone is more problematic due to the fact that the red zone is the critical trauma response of freeze and immobilization, which can result in dissociation and PTSD symptoms.

The relevance in understanding the Polyvagal theory within developing a TIA cannot be underestimated. It is a skilled worker who can develop a conscious approach in maintaining a 'new vagus state', one which models a calm regulated nervous system that nurtures safety, reassurance and provides a woman recovering from trauma the opportunity to co-regulate, supporting her re-entry back into the 'new vagus state'.

It is useful to note that many of the therapeutic techniques and good practice guidance notes offered below, offer strategies that promote and support the switching on of the 'new vagus' state and down regulating the trauma symptoms individuals may be experiencing.

5. Impact of Trauma

The factors influencing an individual's response to trauma are ultimately dependent on the resources available to the individual.

Trauma is a result of our resources being exceeded to cope with the single, continued or complex traumatic events and over-whelming the human system, this leads to a cascade of minor or major disruptions within the human system leading to the following sequela of symptoms.

Table 2. Global impact and sequela of symptoms

	Symptoms
Emotional	Mood swings, hopelessness, fear, anger, hypersensitivity, pre-occupation with danger
Cognitive	Diminished concentration, self-blame, fragmented memory and recall problems, flashbacks, nightmares, phobias
Physical	Sleep / eating problems, gastro-intestinal problems (IBS), impaired immune system, chronic fatigue syndrome, asthma, migraines
Behavioural	Self-harming, suicidal ideation/ activation, risky sexual behaviour, impulsive and aggressive behaviour, irritable, impatient
Interpersonal	Withdrawn, difficulties with trust, problems relating to others, lack of inter-personal boundaries, isolation and sense of alienation, intolerance
Spiritual	Existential crisis, loss of faith, development of false self, unbelonging and loss of sense of wholeness

These symptoms can be experienced in the short-term, however, when experienced over a longer and more chronic period they can result in a number of conditions. Trauma can be life altering, changing the way that an individual views the world and their place within it. It can affect the long-term life trajectory and outcomes particularly for women and girls who have faced repeated and prolonged abuse.

5.i. Clinical conceptualisations of the impact of trauma

The long-term impacts of trauma can be described through three clinical conceptualisations: developmental trauma, post-traumatic stress disorder, and complex traumatic stress (Figure 1, following page). These can provide an essential diagnostic framework to understand how survivors of gender based violence might engage with services, and the interventions they need.

Table 3. Developmental Trauma, PTSD, CTS

Developmental Trauma	Post-traumatic Stress Disorder (PTSD)	Complex Traumatic Stress
<p>•Who it impacts: children and young women who have experienced adverse interpersonal trauma during childhood e.g. harmful practices, child sexual exploitations, witnessing domestic violence</p> <p>•Symptoms: Confusion, depersonalisation, failure to achieve cognitive competencies, interpersonal disturbances, negative self-concept, affect dysregulation</p>	<p>•Who it impacts: Individuals exposed to actual or threatened death, serious injury or sexual violation.</p> <p>•Symptoms: Intrusive thoughts, avoidance, alterations in cognition and mood, alterations in arousal and reactivity</p>	<p>•Who it impacts: Typically, individuals with a history of subjection to totalitarian control over a prolonged period involving situations where the individual is trapped</p> <p>•Symptoms: Alterations in systems of meaning, alterations in somatic experiences, alterations in relationships, alterations in perception of the perpetrator/s, alterations in self-perceptions, alterations in consciousness, alterations in emotional regulation</p>

5.ii. PTSD and Gendered Violence Statistics

- Research indicates prevalence of PTSD in victims of DVA is as high as 63.8% compared to lifetime estimates of PTSD in general populations, at 1% -12% (Golding, 1999).⁴
- PTSD associated with DVA is often untreated leading to chronic mental health conditions (Golding, 1999).
- A study comparing the prevalence and impact of violence against severe mental illness patients and the general population found that compared to the general population, they were at increased risk of domestic and sexual violence, with a relative excess of family violence and adverse health impact following victimization.⁵

⁴ Golding JM. Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence*. 1999;14:99–132.

⁵ H. Khalifeh et.al (2014) Domestic and sexual violence against patients with severe mental illness. *Journal of Psychological Medicine*. Volume 45, Issue 4 pp. 875-886

6. Trauma Informed Approach

In introducing the development and application of a trauma informed approach it is helpful to clarify and make the distinction between trauma informed and trauma specific services.

Table 4: Trauma Informed vs Trauma Specific

Trauma Informed Services	Trauma Specific services
Work at the client, staff, agency and systems levels from the core principles of: trauma awareness; safety; trustworthiness, choice and collaboration; and building of strengths and skills	Are offered in a trauma-informed environment and are focused on treating trauma through therapeutic interventions involving practitioners with specialist skills
Discuss the connections between trauma, gendered violence, multiple complex needs and offer support strategies that increase safety and support connection to services.	Offer services that are based on detailed assessment to survivors of gendered violence experiencing trauma and/or multiple complex needs.

(Adapted from TIP Guide 2016)⁶

⁶ **Trauma Informed Practice Guide (2013):** BC Mental Health and Substance Use Planning Council; Centre of Excellence for Women's Health

6.1. Definition of Trauma Informed care

“Trauma-informed care is a strengths based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.”⁷

A program, organization, or system that is trauma informed⁸:

- **Realizes** the widespread impact of trauma and understand potential paths for recovery;
- **Recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- **Responds** by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively **resist** re-traumatization”
- **Resists Re-traumatisation** of both clients and staff.

6.2. Key Principles of Trauma-Informed Approaches

In practice, an organization which models a TIA, does so by focusing on policies, practices and staff relational approaches to safety and empowerment for clients who come into contact with the organization.

TRAUMA AWARENESS— is the foundation of an organizational culture of trauma-informed care. It begins with building awareness among staff and clients of the prevalence, impact and adaptations made to cope and survive after trauma.

EMPHASIS ON SAFETY AND TRUSTWORTHINESS - Physical, emotional, and cultural safety for clients is key to trauma-informed practice due to the fact that many will have experiences abuse of power in important relationships, and may currently be in unsafe relationships or living situations. Additionally, the safety and needs of practitioners must also be considered within a TIA. Trauma- informed services demonstrate awareness of vicarious trauma and staff burnout. Whether or not providers have experienced trauma themselves, they may be triggered by client responses and behaviours.

⁷ Hopper, Bassuk, & Olivet, 2010 Shelter from the Storm TIC in homeless Service setting. The Open Health and Policy Journal , 80-100

⁸ SAMHSA (2014) Concept of Trauma and Guidance for a Trauma-informed approach

OPPORTUNITY FOR CHOICE, COLLABORATION, AND CONNECTION—

Trauma-informed services create safe environments that foster a sense of efficacy, self-determination, dignity, and personal control for those receiving care. Practitioners try to communicate openly, equalize power imbalances in relationships, allow the expression of feelings without fear of judgment, provide choices as to treatment preferences, and work collaboratively with clients.

STRENGTHS BASED AND SKILL BUILDING—Clients in trauma-informed services are assisted to identify their strengths and to (further) develop resiliency and coping skills. Practitioners emphasize teaching and modeling skills for recognizing triggers, calming, centering, and staying present. Again, a parallel attention must be paid to practitioner competencies and learning these skills and values.

6.3 Working Specifically with Survivors of Gender Based Violence

In working with survivors of gender based violence we can further expand our understanding on how to develop a TIA from principles⁹ that have been designed specifically for services working with women experiencing violence.

Principle 1: Trauma-Informed Services Recognize the Impact of Violence and Victimization on Development and Coping Strategies

For survivors of gendered violence a recognition and understanding of the short and long-term impact of gendered violence is a validation of the difficulties faced in seeking support and the barriers faced. There is an understanding of the pervasive nature of gendered violence which can leave women and girls further vulnerable to poly-victimization, as well as the wider impact on their identity, relationships, expectations of self and others, ability to regulate emotions, and perceptions of the world.

Principle 2. Trauma-Informed Services Identify Recovery From Trauma as a Primary Goal

It is imperative that services operating within a TIA are able to either offer services that directly address recovery from the experiences of trauma or are able to refer to other trauma specific services as a way of ensuring that recovery is the key outcome for women and girls.

⁹ Elliott, D et al (2005): Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women *JOURNAL OF COMMUNITY PSYCHOLOGY* Vol. 33, No. 4, 461–477

Principle 3: Trauma-Informed Services Employ an Empowerment Model

An empowerment model includes developing: an equal and valued partnership between the woman seeking services and the helper; collaboratively and mutually agreed goals for the work; a gendered understanding of violence and abuse; opportunities for peer support; a strengths based approach; increased knowledge of self and others, increased self-worth, and increased competence and comfort in taking action on personal goals; women's resources and skills to be independent.

Principle 4. Trauma-Informed Services Strives to Maximize a Woman's Choices and Control Over Her Recovery

Through promoting choice and control, services re-address the powerlessness women have previously experienced through the experiences of gender-based violence.

Principle 5. Trauma-Informed Services Are Based in a Relational Collaboration

A therapeutic relationship provides a space for the healing of inter-personal trauma, if based on respect, information, connection, and hope further building safety and trust. Trauma informed organizations are aware of not replicating power imbalances that mirror the perpetrator/victim dynamic and actively seek to challenge and readdress any situations where a woman may feel the pressure to conform or comply within any requests/support offered by the organization.

Principle 6. Trauma-Informed Services Create an Atmosphere That Is Respectful of Survivors' Need for Safety, Respect, and Acceptance

To promote the safety, respect and acceptance, organisations may need to make arrangements and modifications to staff approaches, programs, procedures and the physical setting to promote safety and develop a welcoming and calming atmosphere.

Principle 7. Trauma-Informed Services Emphasize Women's Strengths, Highlighting Adaptations Over Symptoms and Resilience Over Pathology

In understanding this principle it is useful to make the shift from the question "What's wrong with you?" to "What's happened to you?" and "What's strong within you?". This offers a paradigm shift away from pathology and towards developing an understanding that trauma symptoms are an adaptive response to traumatic experiences that focuses on a woman's strength and resilience.

Principle 8: The Goal of Trauma-Informed Services Is to Minimize the Possibilities of Retraumatization

Within all interaction, services need to be conscious of any practices, procedures and interactions that have the potential to re-traumatise. This includes an awareness of the power dynamics; sensitively managing disclosures; avoiding the need for explicit detail that can lead to overwhelm; challenging victim blaming and myths that lead to shame.

Principle 9. Trauma-Informed Services Strive to Be Culturally Competent and to Understand Each Woman in the Context of Her Life Experiences and Cultural Background

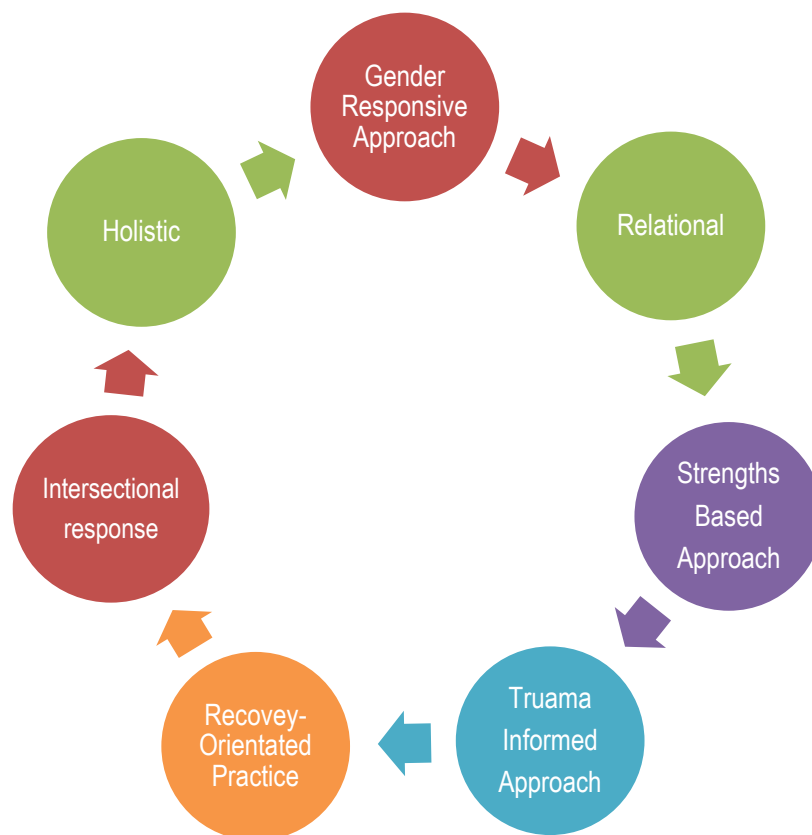
Cultural competency includes having the knowledge and skills to work within the client's culture, understanding how one's own cultural background influences transactions with the client. Additionally, agencies need to develop knowledge on recognizing and effectively supporting women experiencing Harmful Practices as a manifestation of gender based violence (HBV, FGM, FM, Acid Attacks, etc: See WGN Briefing Paper; Hidden Scars).

Principle 10. Trauma-Informed Agencies Solicit Consumer Input and Involve Consumers in Designing and Evaluating Services

A trauma informed organization values survivors as 'Experts by Experience' encouraging them to be involved in designing and the ongoing evaluation of support services.

7. The WGN Application of TIA within WGN 'Holistic Empowerment Recovery Model (HER)

The following model offers an overview of an integrated trauma specific therapeutic model that is applicable to trained clinicians, advocates and support workers. It offers an illustration of how in practice trauma informed principles can be embedded within a care model aimed specifically at survivors of any form of gender-based violence. It is as much unique as it is pioneering, in its understanding of the differing aspects of trauma that need to be addressed to support total and sustainable recovery.

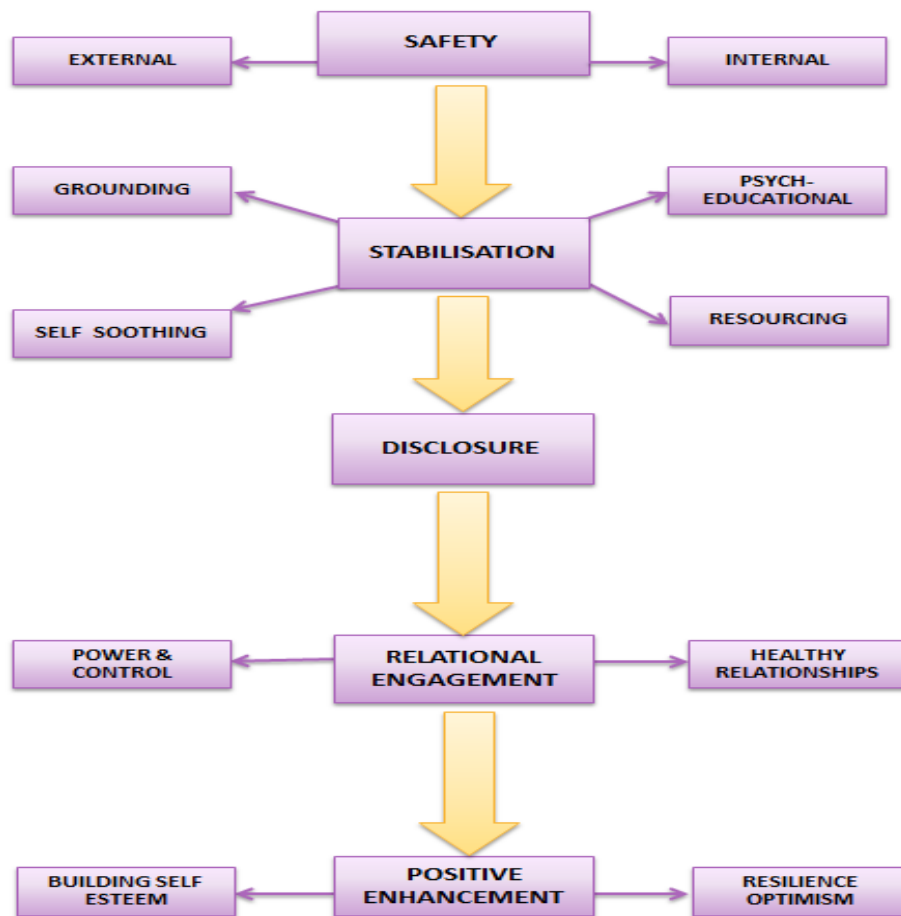


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TIA - Phased approach to working with survivors

- Work needs to be: complex, individualised, multimodal, holistic, multifocal interventions following the unique experiences and impact of trauma
- Holistic in approach to work with global impact of trauma
- Strengths and resilience based approach aimed at personal empowerment
- Culturally significant and relevant
- Trauma / gender responsive
- Recovery orientated practice
- Central is collaboration and mutuality

Figure 3: WGN's Trauma Empowerment Model



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Stage 1: Safety

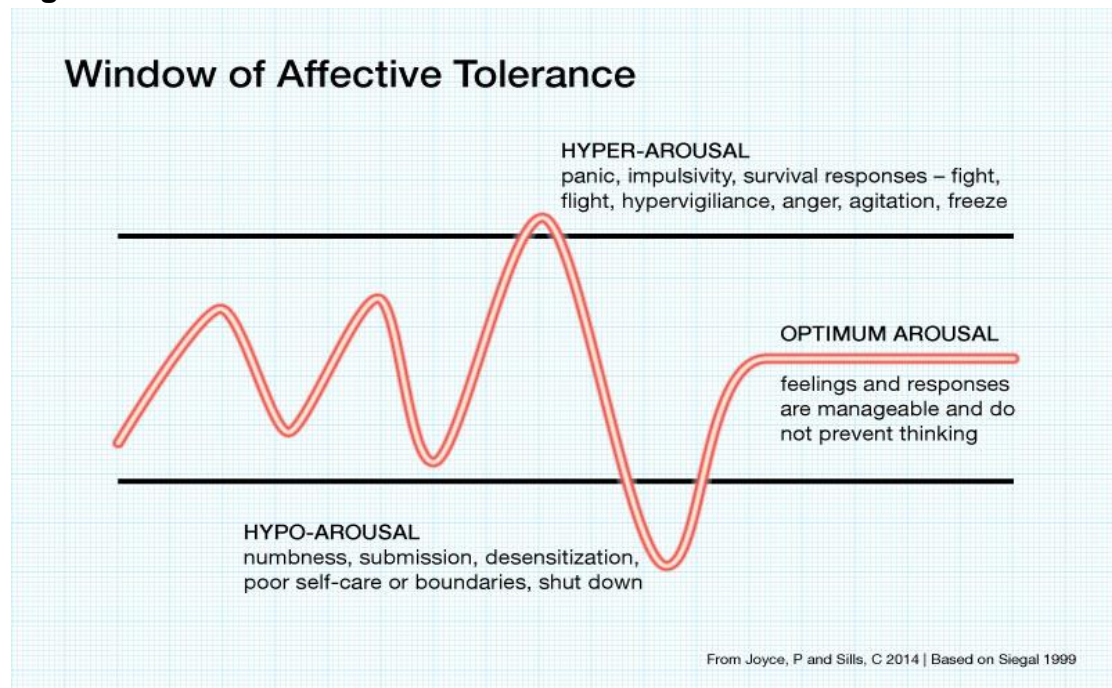
- Evaluating internal threats such as self-harming behaviour
- Evaluating external threats e.g. continued sexual abuse or DV relationship
- Explore / educate on the concept of safety
- Development of a safety plan

Stage 2: Stabilisation

- Understanding of trauma
- Therapeutic window to identify traumatic responses
- Comfort Kit
- Grounding exercises – safe place
- Relaxation exercises – breathing techniques
- Problem solving skills
- Psycho- educational work – normalisation and legitimisation on the impact of gendered violence

- Reality testing – prevalence of gendered violence
- Providing information regarding tactics of perpetrators i.e. exploring coercive control, grooming, power and control wheel to redress the normalisation and internalisation of responsibility to interrupt the blame and shame cycle

Figure 4: Window of Tolerance



Self soothing

- Relearning / developing innate self soothing strategies
- Should be slow, gentle, rhythmical speed or movement
- Soft in texture, tone or hue and quiet in volume
- Such as:
 - guided visualisations / meditation
 - safe place
 - breathing exercises
 - EFT
 - Calming self talk
 - Positive sensations such as warm baths, food, hot drinks
 - Gentle calming music
 - Yoga
 - Body therapies

Self care

- These are activities that tend to be more external, physical, test endurance, strength, offer a sense of accomplishment and ultimately increase self esteem
- The activities require concentration and attention. Such as:
 - physical exercise
 - sports
 - dance
 - gardening
 - painting
 - music
 - computer games

Resource Development

- These are cognitive activities that have to be practised but are designed to have a calming effect
- Positive self imagery – affirmations
- Resource guardian
- Rainy day letter

8. Good practice Guidelines for Engaging clients and embedding a TIA

The following good practice guidelines have been combined from WGN's own model and experience as well as recommended best practice from the referenced guides and current literature. They are intended to high-light tangible actions that practitioners working directly with survivors of gendered violence can take as well as high-lighting areas where further skills and knowledge through training and policy development may be required.

8.1 Developing Safety

Safety and trustworthiness are established through such practices:-

- As welcoming intake procedures
- Adapting the physical space to be less threatening
- Providing clear information about the service
- Ensuring informed consent
- Creating crisis plans
- Demonstrating predictable expectations
- Scheduling appointments consistently
- Considering barriers to access, including the organization's own policies and practices
- Attending to immediate basic needs

- Being transparent, consistent and predictable
- Respecting healthy boundaries by clarifying practitioners roles
- Clearly outline treatment expectations
- Obtain informed consent
- Collaboratively develop grounding strategies
- Safe relationships are consistent, predictable, nonviolent, non-shaming, and non-blaming
- Staff must be aware of the inherent power imbalance in the helper-helped relationship and do their best to flatten the hierarchy
- Clear information and adherence to the confidentiality policy, (with explanations of limitations and information sharing)
- Clear boundaries and well-defined roles are essential to providing a safe environment for survivors.

8.2 Collaboration

Organisations can practice collaboration through: -

- Problem solving barriers to attendance together (accessibility, child care, language etc)
- Adopting a consultative approach
- Eliciting hopes and priorities together
- Inquiring about (safe) others who can support treatment
- Using statements that make choice and collaboration explicit
- Motivational Interviewing
- Utilisation of open-ended questions, affirmations, reflective listening and summaries (also known by the acronym OARS); opening statements; and, agenda setting.

8.3 Choice and Control

Actively promoting choice and control by: -

- Making explicit a woman's right to direct the treatment and support plan
- Clearly stating that the right to refuse treatment and support, answer a question, or request an alternative treatment.
- Recognises and respects the survivors personal agency
- Informing of the right to request a different staff person and modify her services. (if practically possible within the organisations resources)

8.4 Promoting a welcoming, safe and nurturing environment

By providing:-

- A welcoming environment throughout the organisation
- Sufficient space for comfort and privacy,
- Absence of exposure to violent or sexual material (e.g. screen material left in waiting areas)
- Enough staff to monitor the behavior of others that may be perceived as intrusive or harassing.

- Limiting noise and over-crowding
- Avoiding interruptions

8.5 Reducing pathology, promoting strengths and building resilience

Through:

- Adopting a strengths based approach with a focus on healing and total and sustainable recovery as the final goal
- Using language that can normalise and de-stigmatise a woman's response, including re-framing into a more strength's based narrative
- Refer to responses instead of disorders adaptations instead of symptoms
- Skill building, with an emphasis on self protective factors
- Recognising women's wider social roles and identities such as mother, artist, neighbourhood organizer that promotes unforeseen and unrecognized strengths and moves away from identity of 'victim' and or 'survivor'
- Identify and affirm resistance strategies used by survivors to repel, prevent and withstand the domination of perpetrators
- Acknowledge individual resilience and potential for post-traumatic growth

8.6 Minimizing Re-Traumatisation

- Increasing trauma awareness, including recognition of trauma responses and the ability to provide psycho educational explanations to clients of the trauma response and possible adaptations and connections to past experiences. Avoid claiming to be the 'expert' as individuals are 'experts' regarding their own lives and adaptations to traumatic experiences.
- Give advance warning when something out of the ordinary is about to happen.
- Ensure one person undertakes assessments and sensitively asks trauma related questions, therefore avoiding the repetition to multiple workers.
- Respond to disclosure with belief and validation that is gender responsive in its challenge of the violence that has been experienced.
- Challenge myths and victim blaming that are expressed.
- Provide training for practitioners to become versed in de-escalation grounding strategies and ways to support emotional co-regulation.

8.7 Reducing Burn-out and Vicarious Trauma

Key elements of trauma- informed services for reduction in staff burnout and vicarious trauma:

- Acknowledge and normalize the impact of working with survivors of gendered violence
- Provide staff education to increase personal awareness of response to stress including risk factors associated with developing vicarious trauma. (Having a past history of trauma, overwork, ignoring health boundaries, taking on too much, lack of experience, being in the job for years (too much experience), working with large numbers of traumatised children, working with large number of clients who suffer with dissociative disorders.¹⁰
- Ensure access to consistent and effective clinical supervision
- Promoting a culture of reflective practice
- Supporting policies and activities that support staff self-care including the A,B,C model of self-care
 - **Awareness** – Recognise your early warning signs and make adjustments to your work and personal care strategies. Become aware of needs limitations emotions and resources - self monitoring, self-empathy, identify the impact of work on you emotionally, psychologically, physically and recognise own.
 - **Balance** – amongst activities of work play and rest, unconditional compassion for self , limit exposure to traumatic information outside of work i.e. consider what TV you watch, how might you manage work to restore, replenish balance, how do you preserve empathetic connection with self-preserving distance in your work with clients. Introduce proactive steps to prevent mitigate burnout. When confronted with occupational stress tend and befriend rather than fight or flight
 - **Connection** – to yourself, others, and something larger- how do you counter isolation, become more aware of domestic violations and taking clients home, develop and maintain positive relationships outside of home. Friendships connection and acceptance of fun ensuring that you have regular respite helps us to maintain perspective of the real world i.e. a world apart from violence and trauma.

¹⁰ KLINIC Community Health Centre (2013) Trauma Informed, The trauma Toolkit Second Edition. A resource for service organisations and providers to deliver services that are trauma informed.

8.8 Becoming Culturally Competent¹¹

- Intersectionality is a way of taking into consideration all of the factors that together make up peoples political identities including the following aspects of self: gender, race, ethnicity, class and status in society, sexuality, physical abilities and age.
- Intersectionality tries to make visible the multiple factors that structure women's experiences of oppression and against which women have to struggle.
- Cultural competency is congruent behaviour, attitudes and knowledge / policies that enable effectiveness and inclusivity working with diversity and includes the following aspects:
 - Personal awareness
 - Knowledge of own and others cultural landscape including history/ politics and experiences of oppression vs privilege
 - Skills to acknowledge and work sensitively
 - Passion and the ability to communicate empathy and compassion
 - Action to proactively interrupt oppression

8.9 Supporting Survivor Involvement in service design and evaluation

- Providing continuous feedback loops for women to offer feedback about their experiences of the service and support offered.
- Promoting women's voice's to influence decision making at all levels within the organisations including strategy, policy development and implementation.
- An acute awareness of power and control in order to question and challenge whose interests are being met and if they are empowering and enabling to the women being served
- The survivors' voice at the heart should have service user representation on the board of trustees. Service user representation collates information and reviews aspects of the service and reports to the board. Lines of communication and accountability should be clear so that service users know how to communicate their feedback right to the top of the organisation if necessary.

¹¹ Klinik Community Health Centre (2013) Trauma Informed, The trauma Toolkit Second Edition. A resource for service organisations and providers to deliver services that are trauma informed.

9. Trauma Informed Guides and Screening Tools

There are a number of excellent practice guides to becoming trauma informed which are useful companions to organisations who are intending to implement a trauma informed approach or who wish to strengthen and build upon what they currently undertake. The following guides are recommended.

- **Trauma Informed Practice Guide (TIP) (2013):** BC Mental Health and Substance Use Planning Council; Centre of Excellence for Women's Health

The TIP guide is a comprehensive combination of practice-based research and academic understanding of trauma and how to effectively become a trauma informed organisation. Although, developed specifically from the practice experience of those working within the field of substance misuse, the guide is applicable to those wider within health, social care and those working with traumatized individuals. The key objective of the guide is to enhance practitioner awareness and capacity of evidence-based trauma informed practices that can support them to improve the outcomes for the individuals and communities they support who are impacted by violence and trauma. The guide speaks to decision makers, policy planners and practitioners. It offers key guidance on: preparing for trauma-informed practice; engagement; asking about trauma; making links with trauma and skill building and empowerment. There is a valuable check-list to support organisations to undertake and assessment of how effectively they meet the trauma informed criteria.

- **Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol:** Roger D. Fallot, Ph.D. and Maxine Harris, Ph.D.
July, 2009:

The following is a very useful self-assessment scale and planning protocol for organisations to become robust trauma informed services. Aimed at service planners, practitioners and clients it offers clear guidelines on the development, implementation, evaluation and on going monitoring of trauma informed programs. The document offers key domains under which organisations self-assess their current practices to track their level of progress in becoming trauma informed and to support them in developing an implementation plan going forward.

9. Resources for Organisations

Trauma Informed Toolkits and Guides

1. Trauma Informed Practise Guide (2013): BC Mental Health and Substance Use Planning Council; Centre of Excellence for Women's Health
2. Trauma Informed Care Toolkit (2014) Canadian Centre on Substance Abuse
3. Creating a Psychologically Informed Environment Implementation and Assessment
<http://meam.org.uk/wp-content/uploads/2015/11/2015-Creating-a-Psychologically-Informed-Environment.pdf>
4. Stephanie Covington (2017): Gender-Responsive Program Assessment Tool
http://www.stephaniecovington.com/assets/files/5796-65-GenderResponsiveAssessment_Community.pdf
5. The National Child Traumatic Stress Network (2013) Child Welfare Trauma Training Toolkit
<http://www.nctsn.org/products/child-welfare-trauma-training-toolkit-2008>
6. Clinic Community Health Centre (2013) Trauma Informed, The trauma Toolkit Second Edition. A resource for service organisations and providers to deliver services that are trauma informed.
http://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf

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