

How to Manage Trauma

Trauma occurs when a person is overwhelmed by events or circumstances and responds with intense fear, horror, and helplessness. Extreme stress overwhelms the person's capacity to cope. There is a direct correlation between trauma and physical health conditions such as diabetes, COPD, heart disease, cancer, and high blood pressure.

TRAUMA CAN STEM FROM

Childhood abuse or neglect

Physical, emotional, or sexual abuse

War and other forms of violence

Accidents and natural disasters

Grief and loss

Witnessing acts of violence

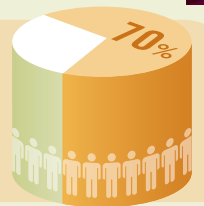
Medical interventions

Cultural, intergenerational and historical trauma

TRAUMA

HOW COMMON IS TRAUMA?

70% of adults in the U.S. have experienced some type of traumatic event at least once in their lives. That's **223.4 million people**.

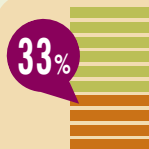


+90%

In public behavioral health, **over 90%** of clients have experienced trauma.

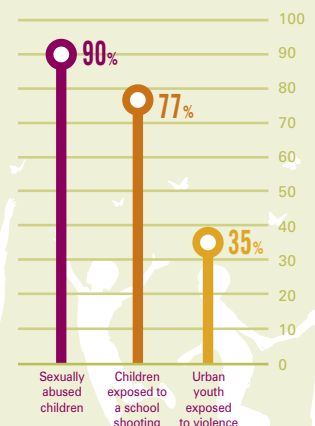
Trauma is a risk factor in nearly all behavioral health and substance use disorders.

In the United States, a woman is **beaten every 15 seconds**, a forcible rape occurs every 6 minutes.



More than **33% of youths** exposed to community violence will experience Post Traumatic Stress Disorder, a very severe reaction to traumatic events.

Nearly all children who witness a parental homicide or sexual assault will develop Post Traumatic Stress Disorder. Similarly, 90% of sexually abused children, 77% of children exposed to a school shooting, and 35% of urban youth exposed to community violence develop Post Traumatic Stress Disorder.



Post-traumatic stress disorder (PTSD) is a mental health condition that's triggered by a terrifying event. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event.

*People can and do
recover from trauma*



SYMPTOMS OF TRAUMA CHECKLIST

- ☐ Headaches, backaches, stomachaches, etc.
- ☐ Sudden sweating and/or heart palpitations
- ☐ Changes in sleep patterns, appetite, interest in sex
- ☐ Constipation or diarrhea
- ☐ Easily startled by noises or unexpected touch
- ☐ More susceptible to colds and illnesses
- ☐ Increased use of alcohol or drugs and/or overeating
- ☐ Fear, depression, anxiety
- ☐ Outbursts of anger or rage
- ☐ Emotional swings
- ☐ Nightmares and flashbacks — re-experiencing the trauma
- ☐ Tendency to isolate oneself or feelings of detachment
- ☐ Difficulty trusting and/or feelings of betrayal
- ☐ Self-blame, survivor guilt, or shame
- ☐ Diminished interest in everyday activities

HOW TO TALK TO YOUR DOCTOR

- ☐ Make your doctor aware that you have experienced trauma, past or recent
- ☐ Help them understand what is helpful to you during office visits, i.e., asking permission to do a procedure, staying as clothed as possible, explaining procedures thoroughly, or having a supporter stay in the room with you
- ☐ Ask for referrals to therapy and behavioral health support



HELPFUL COPING STRATEGIES

- ☐ Acknowledge that you have been through traumatic events
- ☐ Connect with others, especially those who may have shared the stressful event or experienced other trauma
- ☐ Exercise — try jogging, aerobics, bicycling, or walking
- ☐ Relax — try yoga, stretching, massage, meditation, deep muscle relaxation, etc.
- ☐ Take up music, art, or other diversions
- ☐ Maintain balanced diet and sleep cycle
- ☐ Avoid over-using stimulants like caffeine, sugar, or nicotine
- ☐ Commit to something personally meaningful and important every day
- ☐ Write about your experience for yourself or to share with others

ASK YOUR HEALTHCARE PROFESSIONAL ABOUT TREATMENTS

TRADITIONAL TREATMENTS

Cognitive Behavioral Therapy
Eye Movement Desensitization and Reprocessing (EMDR) Therapy
Talk Therapy
Exposure Therapy
Group Therapy

ALTERNATIVE TREATMENTS

Energy Processing
Hypnotherapy
Neuro-Linguistic Programming
Massage Therapy
Pet or Equine Therapy
Trauma and Recovery Peer Support Groups
Wellness Recovery Action Planning (WRAP)



NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE



For more information, interviews, and research on trauma check out the National Council's magazine edition on the topic

www.TheNationalCouncil.org

Overview Phase Oriented Care

Phase Oriented Treatment for Trauma (Herman 1992, Janet 1889)

From Courtois, C. “Treating Complex Traumatic Stress Disorders”

Phase One: Safety and Stabilization

- Motivation for Treatment- Common Factors Module in EL, MI Training
 - Informed Consent
 - Education about what Treatment is
 - Treatment Relationship Begins – Common Factors Module in EL
 - How you will assess trauma
- 1) Personal and Interpersonal Safety Established: Education/Support/Safety Planning
 - 2) Enhance Client’s ability to manage extreme arousal (hyper/hypo)
 - 3) Active engagement in positive/negative experiences (deal with automatic avoidance behaviors, self awareness of avoidance, increase coping skills and use of coping skills)
 - 4) Education (psychotherapy, trauma, skills to be learned) – Stress Model
 - 5) Assess and develop relationship capacity (decrease avoidance of relationships or negative thoughts about relationships, build support network, define client’s attachment network)

Phase Two: Processing Traumatic Memories

- 1) Disclosure of traumatic memories, development of an autobiographical narrative (identify emotions connected to trauma memories, grieve and mourn losses, resolution of relationships when appropriate, increased awareness, increase interpersonal and self-regulation skills)
- 2) Supporting client in maintaining functioning and not getting lost in memories or seeing themselves as “disabled”, need to affirm strengths, promote positive self-esteem, and internal and external resources now available to them

Phase Three: Reintegration

- 1) Growth and period and reengagement in life
- 2) Can be time of client realizing losses, discover of unresolved developmental deficits, fine tuning of self-regulation skills

Common Challenges:

- Continuing to develop trustworthy relationships
- Sexual Functioning
- Parenting
- Career/educational life decisions
- Ongoing self-protection
- Confronting abuse and neglect perpetrated by others

Skill Building Suggestions and Examples

PHASE ONE: Safety and Stabilization

Emotional Distress (“aloe on sunburn”)

- ACCEPTS model
- Galvanic Skin Response (hand-warming)
- Distraction (mandala)
- Bilateral Movement
- Vacation “meditation”
- “Just Worrying” Skill

Self-Regulation (“sunscreen”)

- Mindfulness Scale (MAAS)
- Mindfulness Exercise (sheet) – breathing, “one thing”
- Self-Care Plan (daily practice)

Self-Awareness (“knowing your skin”)

- Critical Awareness Skills (Brene Brown)
- Checking the Facts (DBT)
- Self Compassion Work (Kirsten Neff)

Education on Body and Complex Trauma (“checking the weather”, “knowing your location”)

- Trauma Psycho-Education Documents
- Downstairs/Upstairs Brain
- Fight/Flight/Freeze Picture

Relationship Skills (“bringing a friend to the beach”)

- Empathic Communication Skills (mirroring)
- Change/Acceptance
- GIVE skills
- DEAR MAN
- Dialectical Thinking (middle road)

PHASE TWO: Re-Processing Memories

- Film Projector
- Re-Wind Technique
- Gathering a Trauma Narrative
- EMDR and Progressive Counting
- Exposure Methods (Prolonged Exposure and Cognitive Processing Therapy)

PHASE THREE: Reintegration/Daily Life ... amplifying strengths to other life domain areas

- Supporting beliefs that client deserves “good” things
- Recognizing “bumps in the road” don’t mean “a crash”

CASE EXAMPLES

Case Exemplar

Youth and Family Case

Client is a 16 year old African American male reporting opposite sex intimate relationship preferences. He was referred for sexually abusive behavior problems after being placed on probation for sexually exposing himself to his younger brother 6 months prior to his intake session for counseling services. He is currently on probation for this offense, must comply with the rules of probation, complete sexual abusiveness therapy (group, individual and in home), and comply with all components of his risk safety plan including not being alone with children under the age of 12 at any time.

Client lives with his mother and younger brother. His father moved out of the home approximately 7 months prior to initial interview. As reported by mother and father, interpersonal violence has been a common occurrence in the family throughout Leonard's life (client). From the age of 3-11, Leonard can recall emotionally and physically abusive interactions between his parents including yelling for long periods of time, verbal threats from his father towards his mother, incidents when his father pushed his mother into walls, broke furniture, and destroyed other family property. At the age of 11, violence in the home escalated. Leonard had begun to physically protect his mother resulting in arrests of his father and him. Leonard received 2 Simple Assault on a Family Member charges at the time of intake assessment. Seven months ago through a plea bargain, Leonard's father received the charge of simple assault on a family member in return for signing a civil order of protection for Kirsten. Jay moved out of the family home and has remained out of the home for 7 months as reported by Leonard and his mother.

Leonard is in good overall physical health. He received a physical within the last 8 months, is up to date with immunizations, and no medical concerns were found. Leonard has struggled in school since the 2nd grade. He is in the 9th grade and his reading level is that of a 5th grader. His IQ is above normal (110). He often visits the principal's office for school fights and has been suspended on three occasions for fighting this year.

Leonard reports using marijuana on a few occasions (4 times in last year) and drinking alcohol more often (1-2 times per month). He reports this pattern continued until he was placed on probation 6 months ago and now since he is given regular urine screenings he has given up both substances. He has had no negative drug screens in the last 4 months (time on probation).

PRESENTING PROBLEM:

Leonard was referred specifically for sexually abusive behavior (exposure of his penis to his younger brother). He reports that his brother asked him to show him his penis when he was putting him to bed one night and he did. When he was showing his brother his penis, his mother walked in the room and became very upset and called the police. Mother reports that while she

was concerned about the sexual exposure, she was even more concerned about his academic performance, fighting, and explosive temper in the home. She reported “He is just like his father”. She stated that she and Leonard get into frequent verbal arguments since his father left the home and at times she hit him to get him to calm down. She reported he had destroyed property in the home since his father left and that there was a constant power struggle between them.

STRENGTHS:

Leonard showed empathy towards his mother and brother and remorse for his sexually abusive behavior. Leonard showed a sense of humor and curiosity about therapy during the assessment. He was open about his family life history and reported wanting to learn new skills even though he had little hope that his relationship with his Mom would get better. He stated, “She thinks I am just like my Dad and won’t give me a chance ... maybe I am just as bad as him”. He presented with motivation to try therapy and was beginning to engage in the therapeutic relationship with the counselor who conducted his individual, family, group and in home counseling after assessment was completed.

Social Support Systems

Leonard reported having about 5 male friends he regularly spent time with in the neighborhood and that attended his school. He reported three of them had charges for “slinging” (selling drugs). He reported he did not sell drugs even though it is tempting with the family being so strapped for money. He and his mother were having communication challenges and frequent arguments. He reported that his maternal aunt lives close by and was supportive of him. He liked one of the basketball coaches at the local Boys and Girls Club and talked to him sometimes and occasionally went to midnight basketball there on Saturdays. Leonard reported not getting along with many adult males outside Mr. Murphy (basketball coach). He occasionally saw his father (once a month) since he moved out and they would go to McDonald’s for a while and talk. He reported missing his father but knowing it is best for him to not be in the home because of all the violence that occurred when he was there.

OUTCOME MEASURES:

Trauma History:

UCLA- PTSD index

Total Score = 44

Met Criteria for B,C,D but not E (dissociative)

Therefore symptoms of re-experiencing, avoidance, and heightened arousal are present

Youth Expectations/Satisfaction:

Therapeutic Alliance Quality Scale (TAQS)

Leonard scores the therapeutic relationship at a 2 out of 5, this is in a clinically concerning zone

Notes he didn't understand what his counselor was talking about in the last week and doesn't feel they are working together, did note that he had some belief (3 out of 5) that counselor would stick with him no matter what

Therapeutic Alliance Quality Rating (TAQR) – not completed

CHS-PTPB (Youth Hope Scale) Range is 1-4 (higher better) – Scores a 2

BMSLSS-PTPB (Youth Life Satisfaction) Range is 1-5 (higher better) – Scores a 2

Caregiver Report of Symptoms:

Caregiver SFSS-PTPB (Symptom Functioning Severity Scale)

Range is 42-105, clinical cuts offs at 58 and 73 (low, medium, high)

Scores Leonard at a 78 (internalizing at a 20 and externalizing at a 79)

Youth Report of Symptoms:

Youth SFSS-PTPB (Symptom Functioning Severity Scale)

Range is 32-107, clinical cuts offs at 45 and 63 (low, medium, high)

Scores himself at a 63 (internalizing at a 33 and externalizing at a 46)

Alcohol/Drug Abuse Screen

Included in SFSS – as 2 items (checked not for present use of alcohol or drugs)

Caretaker Functioning**Satisfaction with Life Scale (SWLS)**

Range is 0-7, 3.5 & 7.5 cutoffs (higher is better)

Mom scores herself at 3.5

Caregiver Strain Questionnaire–Short Form7 (CGSQ-SF7)

Range 1-10, 4 and 7 cut offs (higher is worse)

Mom scores herself at 7

Youth and Family Case Exemplar Assessment and Treatment Planning Notes

Exemplar Goals:

For the purposes of this case study, develop 2-3 treatment goals that do NOT focus on the sexually abusive behaviors mentioned in case study. In the actual case this exemplar was based on, Leonard had a treatment plan dedicated to his offense cycle and sexual abusiveness work as well as other treatment goals.

In working with you, Leonard and you have identified the following three goals for treatment:

- 1) _____

- 2) _____

- 3) _____

Exemplar Interventions:

Goal One Target Interventions:

Goal Two Target Interventions:

Goal Two Target Interventions:

Phase One:

Self Regulation, Mindfulness, Interpersonal Effectiveness, and Distress Tolerance Skills

DAY ONE: TIC AND DIRECT SKILLS APPLICATION

SELF REGULATION AND MINDFULNESS

SELF-REGULATION - Ability to express emotions in any given situation in a way that is

- Socially Acceptable (at-promise health behavior vs. at-risk health behavior)
- Let's regain balance when difficult moments pass

MEANS **"Staying in the Zone"** or getting back to the **"Zone"** successfully

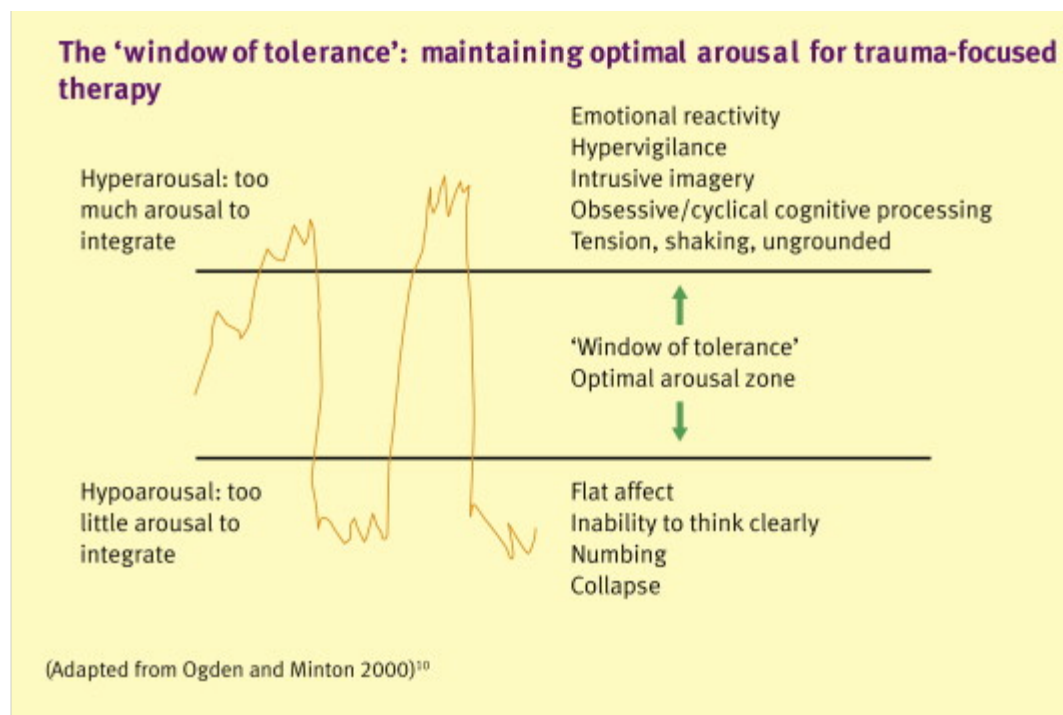
MINDFULNESS - Art of being present in the moment

Helps us **"stay in the zone"** and get back to **"the zone"**

Skills that help us concentrating our attention on what we choose rather than having emotions, thoughts, or other experiences (trauma echoes) control us

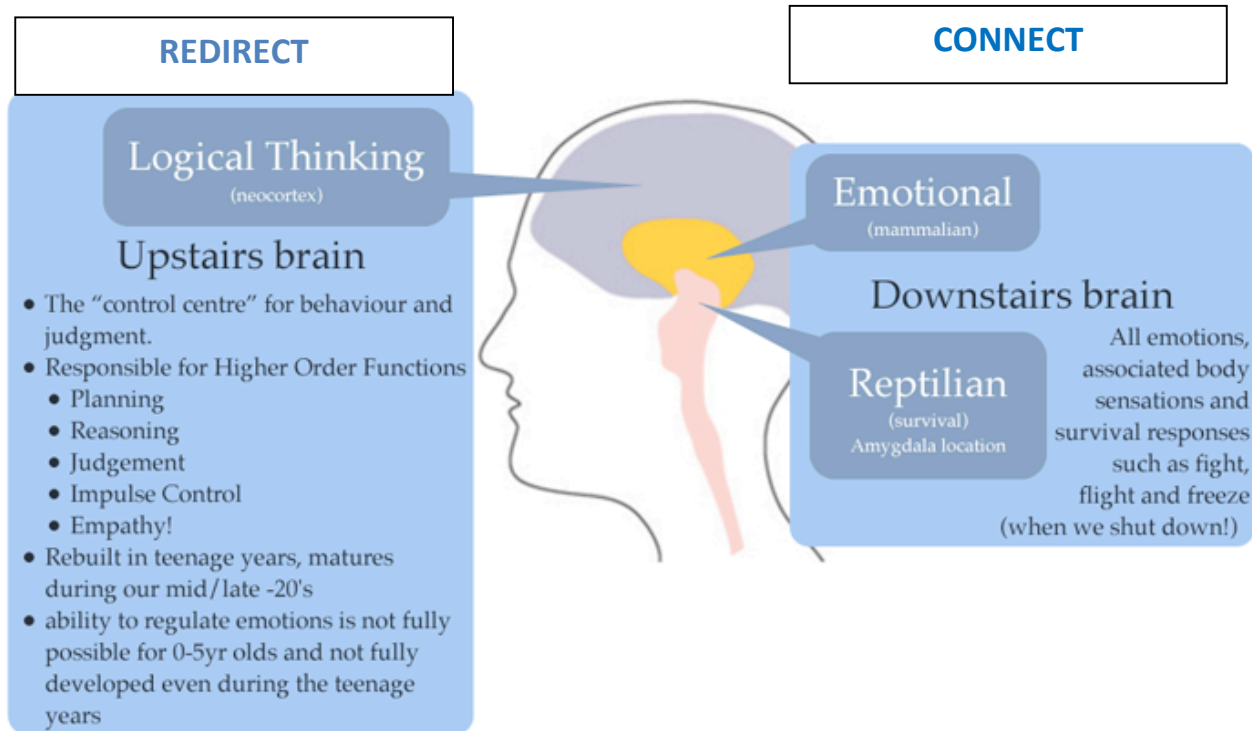
Skills that help us move from our "downstairs brain" to the "upstairs brain"

Skills that help us prevent and intervene when our "upstairs brain" gets emotionally hijacked



BODY SCAN SKILL: Begin your body scan by diverting your thoughts away from any mental chatter, switch gears by first focusing on your feet. Do not rush! During the process you will slowly change your focus from one part of your body to the next. Also, you don't need to touch yourself, the scan is mental. Allow your mind to switch focus from wherever it is. Begin with your feet and move upwards. On a scale of 1-10, 1 being most relaxed, 10 being most tense, where are you?

Mindfulness is a critical skill to practicing effective communication with others ... Remember, when someone is in their downstairs brain, the best interventions involve connection. When someone has access to their upstairs brain, you can include interventions that involve connection and redirection.



<http://peacefulparenting.com.au/>

Relationship Effectiveness with GIVE (from DBT skills)

Describe ways to be **Gentle** with your communication:

Describe what you will do or say to act **Interested**:

Plan to **Validate** the other person’s thoughts/feelings/behaviors by saying:

Describe any strategies for keeping the conversation light with an **Easy Manner**:

Emotional Distress Skills (“aloe on sunburn”)

ACCEPTS (Activities; Contributions; Comparisons; Emotional Opposite; Pushing away; Thoughts; Sensations)

Distraction Skills for Reducing Distress

Pederson, L. (2012). *The Expanded Dialectical Behavioral Therapy Skills Training Manual*. Eau Claire: CMI Education Institute, Inc. pp. 45-50

- Activities (physical and mental) – mental vacation, bi-lateral movement (walking), temperature change
- Contributing – helping others gets you out of yourself and your stress (smiling, give compliment, invite someone to coffee, hold a door, do a favor)
- Comparisons – Bringing perspective to current situation, what skills have helped you cope before (have helped your children cope before) ... validate yourself
- Emotions – Seek out activities that create feelings that are OPPOSITE from the painful ones you are experiencing (listen to music, favorite movie, work on a project --- favorite hobby)
- Push Away – Put away distressing memories in a “lock box” or in the “parking lot” for a little while ... can do this in writing or mentally
- Thoughts – distract your thoughts with “one-thing” exercises, read something inspiring, “just worrying exercise”
- Sensations – Any physically vigorous activity or actively awakening senses (brisk walk, cold bath/hot bath, splash cold water on face, lotions on your wrist, strong taste, bold colors (Mandela), music)

ACTIVITY:

Over the next 15 minutes, work with your table partner to think about ways you could help a youth or caregiver begin to build a safety plan with coping skills from ACCEPTS.

If it helps, you can brainstorm with your table partner times you each have been stressed at work, what ACCEPTS skills could you use at work to help you climb back up Vulnerability Mountain? Get specific

ACCEPTS SKILLS PLAN:

Phase One:
Positive
Self-Identity
and
“Being
Enough”

Shame and Shame Resilience

Taken from Dr. Brene Brown

Brené Brown. *Daring Greatly: How the Courage to Be Vulnerable Transforms the Way We Live, Love, Parent, and Lead*. Gotham Books, 2012. (287 pages)

Chapter 3

WHAT IS SHAME AND WHY IS IT SO HARD TO TALK ABOUT IT?

1. We all have it. Shame is universal and one of the most primitive human emotions that we experience.
2. We're all afraid to talk about shame.
3. The less we talk about shame, the more control it has over our lives.

...shame is the fear of disconnection (68)

Shame is the intensely painful feeling or experience of believing that we are flawed and therefore unworthy of love and belonging. (69)

Twelve “shame categories have emerged from my research:

- Appearance and body image
- Money and work
- Motherhood/fatherhood
- Family
- Parenting
- Mental and physical health
- Addiction
- Sex
- Aging
- Religion
- Surviving trauma
- Being stereotyped or labeled

Guilt = I did something bad

Shame = I am bad

Embarrassment = Fleeting, can laugh about it later

Humiliation = “I didn’t deserve that”

I GET IT. SHAME IS BAD. SO WHAT DO WE DO ABOUT IT?

The answer is shame *resilience*. Note that shame *resistance* is not possible. (74)

I mean the ability to practice authenticity when we experience shame, to move through the experience without sacrificing our values, and to come out on the other side of the shame experience with more courage, compassion, and connection than we had going into it. Shame resilience is about moving from shame to **empathy** — the real antidote to shame. (74) Here are the four elements of shame resilience — the steps don't always happen in this order, but they always ultimately lead us to empathy and healing:

1. **Recognizing Shame and Understanding Its Triggers.** Shame is biology and biography. Can you physically recognize when you're in the grips of shame, feel your way through it, and figure out what messages and expectations triggered it?
2. **Practicing Critical Awareness.** Can you reality-check the messages and expectations that are driving your shame? Are they realistic? Attainable? Are they what you want to be or what you think others need/want from you?
3. **Reaching Out.** Are you owning and sharing your story? We can't experience empathy if we're not connecting.
4. **Speaking Shame.** Are you talking about how you feel and asking for what you need when you feel shame?

C.A.R.E CERTIFICATION

WHAT DOES IT MEAN TO C.A.R.E? WHAT IS THE IMPORTANCE OF CALM, ACCEPTING, RESILIENT AND EMPATHETIC SKILLS AS A PROFESSIONAL?

Assuring a strong *Trauma-Informed / Emotional Agility & Resilience™* foundation for all leaders, direct care staff, and consumers is a critical component in responding to the public health crisis of childhood trauma. This is where the C.A.R.E. Certification learning series strives to provide a flexible solution.

Dr. Allison Jackson has created a five-part educational series dedicated to enhancing human service professionals' knowledge of *Trauma-Informed* perspective and practices. Integration Solutions partnered with Narutka International to provide you and your organization options to access this program through an online learning platform, webinar or live workshop.

The five course modules included in the core C.A.R.E. Certification are:

1. Overview Adverse Childhood Experiences (ACEs): The Most Basic Public Health Issue
2. Emotional Trauma's Impact on the Brain and Behavior
3. Introduction to Emotional Agility & Resilience: Building Individual Resilience with Every Day Action
4. Vicarious Trauma: Importance of Self-Care for Professionals
5. Community Resilience and Next Generation Health

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About the Creator of the C.A.R.E. Certification



For nearly 30 years, Dr. Allison Jackson has been working in the field of *Trauma-Informed / Resilience*. The majority of her career path has involved supervising/consulting nationally and internationally with professionals assisting patients/clients with Adverse Life Experiences (ACEs). She also continues to work directly in this field with clients in her community.

Dr. Allison's passion was ignited while educating the human service workforce in basic principles of *Trauma-Informed / Resilience*. As a distinguished leader, she educated professionals on evidence-informed approaches to clinical and organizational practices.

Dr. Allison is equally committed to the health and well-being of the Professionals serving clients and their support network. Her development of a *Trauma-Informed / Emotional Agility & Resilience* educational curriculum became the topic of her PhD research, where she evaluated and implemented the best methods for adult learners in human services to:

- A. Understand the impact of childhood adversity/trauma on health, learning and relationships,
- B. Gain knowledge in the concepts of *Trauma-Informed Care / Emotional Agility & Resilience*,
- C. Learn evidenced informed practices in being a *Trauma-Responsive / Emotionally Agile & Resilient Professional*

Dr. Jackson now harnesses the compelling research in the field of Adverse Childhood Experience (ACEs) and Resilience, her academic and clinical experience, and her personal experience as a trauma thriver to bring forward the C.A.R.E. Certification. Her hope is that all C.A.R.E. Certified professionals will practice **C**alm, **A**ccepting, **R**esilient and **E**mpathic

