

TRAUMA INFORMED CARE



**A HISTORY OF HELPING
A HISTORY OF EXCELLENCE:
LESSONS LEARNED SINCE 1990**

William Steele, PsyD, MSW



**THE NATIONAL INSTITUTE
FOR TRAUMA AND LOSS
IN CHILDREN**

**A STARR INSTITUTE
FOR TRAINING PROGRAM**

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CONGREGANT/ATI
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The National Institute
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INTRODUCTION

Dr. Steele founded the National Institute for Trauma and Loss in Children™ (TLC) in 1990 long before children were included in the diagnostic category of Posttraumatic Stress Disorder (PTSD). He began developing and researching trauma-specific interventions in 1990 beginning with a one-session trauma-specific intervention. Today his model *Structured Sensory Interventions for Traumatized Children, Adolescents and Parents (SITCAP™)* is used in thousands of schools and agencies across the country and undergoes continuous field testing and rigorous evidence-based research. Outcomes have consistently demonstrated remarkable, statistically significant reductions of trauma and associated mental health symptoms. Over 5,000 professionals have been certified as Trauma and Loss Specialists by TLC under Dr. Steele's supervision. He encourages you to visit TLC's website (www.starrtraining.org/tlc) for more detailed information

Given past and recent research about trauma in addition to twenty years of experiences working with traumatized children and adolescents, adults, families, schools and communities, the following lessons learned have been integrated into the evidence based SITCAP™ model. They represent what we know about trauma as an experience and provide the core sensory focus trauma specialists must use to guide and structure their

interventions. Intervention must be very structured and directed at sensory/implicit functions that lead to the diminishing and eventual alternative to the trauma-related sensory memories in order to reframe those experiences in ways traumatized children can manage as well as call upon as a resource in their ongoing efforts to survive.

These lessons learned are the starting point for helping traumatized children regardless of the format used – individual or group intervention - regardless of the setting – school setting, agency, community mental health, detention, residential settings. Many of these lessons are presented in various publications by Dr. Steele can be found in the reference section. A partial reference list of other leaders in the field of trauma who have guided Dr. Steele’s work the past twenty years. (References earlier than 1995 are not listed, yet earlier discoveries about children’s’ responses especially to traumatic violent exposure remain relevant today.) Some lessons will be restated because of the critical role they play in helping traumatized children find relief from the terror of their experiences.



TRAUMA AS AN EXPERIENCE

We want to relate to trauma as an experience, not as a diagnostic category. One word that best captures the experience of trauma is terror. We define the experience of terror as feeling totally unsafe and powerless to do anything about one's situation. If this is the primary experience of trauma it follows that intervention must be directed at the restoration of this sense of safety and power.

1. Helping the child experience a sense of safety is critical to relieving the experience of trauma.
2. However, safety cannot be experienced through cognitive processes alone; it must be first experienced at a sensory, implicit level in the deep mid-brain rather than the neocortex, upper brain region.
3. Trauma is the inability to move the sensory memo-

ies of those traumatic experiences from implicit to explicit memory where the child can reframe the memories in ways he can now manage, use as a resource and view himself as a survivor/thriver versus a victim.

4. Keep in mind that because the experience of trauma is sensory/implicit, the way we look, approach the child, the pitch of our voice, etc. can remind that child of that bad person who did that bad thing to him. He may not be able cognitively to determine that although something about us triggers or activates his survival response, we are not the same person who did that bad thing to him. We may be very skilled trauma specialists, just not the right person in that child's sensory memory. In trauma work, we need to work in teams when possible so that the child has a choice as to whom he lets help him to feel safer. Therefore, there is no such thing as resistance in trauma. Either the child experiences us as someone who is safe or he does not. Little progress will be made if we are experienced to be unsafe. In fact, we may see an increase and/or intensification of those survival behaviors if we do not connect that child to someone they do experience as safe.

5. When a traumatized child's behavior does not make sense, remember the experience of trauma is one of terror, which activates deep and midbrain survival response (reptilian and emotional responses). The traumatized child's behavior, as illogical as it may seem, is

an attempt to regain power over the "who" or "what" in his life that is perceived to be a threat; to get to a point that implicitly leaves him with a sense of safety and control. From a "non trauma" perspective the child's behavior may look like self-defeating behavior yet, from a trauma perspective, his behavior allows him to momentarily feel safe and in control.



6. Living in the trauma experience children are unable to cognitively distinguish that the threat is over. In trauma treatment, therefore, we must help the child with the "then" and the "now". Whenever we make a reference to the "then" of his experience we must always bring him to the "now" of his experience; this very day and time and the fact that he is with us.

7. Furthermore, the more frequently the traumatized child can distinguish the present from the past the more opportunities we have to help him reconnect to the future. We must continue to remind every traumatized child that, "today is followed by tomorrow and tomorrow you will...". Here we must be pa-

tient and also help the child experience patience for what he hopes for and plans for tomorrow and weeks later.

8. The more often we can help the child identify what he would like to experience tomorrow and provide the appropriate opportunities to do so, the more he can begin to move out of the past and move forward to the next day in his life. Repeating this pattern day after day helps build trust that, even though some days may be harder or more disappointing than others, tomorrow is another day and another opportunity.



9. One cannot reduce deep, mid-brain dominance via cognitive processes alone. Cognitive processes are located within the neocortex not in the deep midbrain areas where trauma is experienced and stored. This deep brain dominance is often in the aroused state, chronically ready for the next bad thing to happen. The child is aroused and poised to survive (hyper arousal). He is vigilant and ever ready. The physiological state of arousal reduces the ability to cognitively

reason, to cognitively evaluate potential danger and then determine appropriate behavior. He doesn't think, just acts by engaging the primary survival responses (flight, fright, freeze). When arousal can be reduced, survival responses diminish and cognitive process becomes more accessible.

10. There a number of sensory strategies which can be used to reduce arousal. One of the simpler strategies is to teach the child to recognize differences in his body when stressed versus relaxed and then engage the child in activities which replicate the relaxed state. This gives the child a sense of mastery as well as confidence that he has some control over how he responds.
11. In trauma treatment children must be directed to their body's response to any stressor, so they can learn to use this response as a control point, as a place to begin to reduce their arousal/anxiety via use of past repetitive practice of moving in and out of stressed/relaxed body states. This repetitive process helps him to distinguish good stress from bad stress, which is an executive function.
12. By repetitive body conditioning the child can learn that although he may still face difficult situations he can regulate his arousal response.
13. Body awareness and control leads to self-regulation, which diminishes the deep mid-brain dominance and

can provide access to those cognitive functions needed to attend, focus, retain, recall, communicate, problem solve and consciously regulate one's reactions.



14. Increasing a child's time devoted to play, positive fantasies (especially about self as empowered) and increased use of imagination also become excellent strategies for reducing deep midbrain dominance while increasing sense of empowerment.
15. From a neurological stance, safe experiences develop new memory synapses and repetition of these safe experiences lead to synaptic connections that in time diminish the responses to unsafe, sensory memories.
16. Reduction of posttraumatic stress symptoms and other trauma-related mental health symptoms can be experienced without focusing on symptoms. Initiating sensory based activities which address the major experiences of trauma (terror, worry, hurt,

anger, revenge, accountability, feeling unsafe and powerlessness) can begin to restore that sense of safety and power in the child and result in the diminishing of trauma related symptoms.

17. In trauma treatment we must always provide the child with choice, if we are going to help him develop a sense of empowerment. This choice includes not wanting to engage in any intervention we might suggest. Having choice leads to self-regulation.



18. When working at the sensory level we must work hard to see what the child now sees as he looks at himself and the world around as a result of traumatic exposures. We need to see how he now views himself, others and his environment, to truly know how to best help as well as not over intervene.
19. It is critical that we do not make assumptions about how that child has been impacted by any experience we think should or should not be traumatic. Remem-

ber that an experience is only traumatic if the child's experience of it is one of feeling totally unsafe and powerless to do anything about that situation.

20. We can actually over intervene and induced greater amounts of anxiety than were actually experienced by the child when we assume that we know what it must be like for the child. Ask two children exposed to the same situation what worries them the most since this happened. One will reply, "Does this mean we can't go on our field trip?" while the other replies, "Is mommy going to die too?" One exposure, two different experiences, two different interventions.

21. In trauma, behaviors reflect the sensory experience. These sensory experiences cannot be changed by cognitive interventions alone, as most are not stored in the neocortex region but the deep midbrain regions. Sensory memories must be changed through sensory interventions if traumatic driven behavior is to change.

22. When memory cannot be linked linguistically in a contextual framework, it remains at a symbolic level where there are no words to describe it. To retrieve that sensory memory so it can be encoded, given a language and then integrated into executive "explicit" functioning, it must first be retrieved and externalized in its symbolic, perceptual (iconic) form. This is an implicit process, which can only be accom-

plished through sensory interventions.

23. For sensory interventions to be effective they must be structured so each session begins and ends in a safe place while, in the middle of the session, sensory interventions direct themselves to the specific experiences or themes of trauma: fear and terror, worry, hurt, anger, revenge, accountability, feeling unsafe, powerless and trapped by victim thinking versus survivor thinking.

24. It is critical that the child be actively involved in his own healing process by providing the child the opportunity to:
 - a) Focus on internal resources (sensory)
 - b) Re-work the experience while, at the same time, experiencing sensory relief from the terror of that experience(s).
 - c) Experience positive, sensory reattachment to their own bodies.
 - d) Experience at a sensory level a renewed sense of safety and power as a result of engaging in sensory directed experiences.
 - e) Translate this renewed sense of safety and power into a “cognitive” identity as a survivor and thriver.

26. Attempts to cognitively reframe what is not first experienced at a sensory level will not make sense to the traumatized child because, the dominant process of the traumatized brain is sensory, not cognitive which is why understanding, logic, reasoning are difficult to access.

27. Attempts to introduce reframing statements and thoughts that are not directly related to a sensory experience cannot be internalized. You tell me I can run a marathon but after ten minutes of jogging for the first time I start having side stitches and have to stop because I'm out of breath. What am I going to believe? The cognitive conviction flows from the sensory experience. If you had told me I could jog for ten minutes I would have believed you, because my body proved it. When you tell me after a few ten-minute body successes that I can jog for fifteen minutes, I will be eager to try because my body, my sensory experience, supports the possibility.



28. To cognitively accept him as a survivor/thriver, the child must first discover repeatedly, at the sensory level, the ability to regulate his aroused survivor responses to his environment, to his day-to-day interactions within that environment and the situations created by that environment.



29. Cognitively, children will generally be farther behind their peers as developmental learning processes are delayed when faced with ongoing trauma. The dominant brain functions when “stuck” in trauma are deep mid-brain functions not upper brain functions. Once the mid-brain is no longer the predominant processor of daily life, children can often learn at three times the rate compared to when engulfed in trying to survive.
30. Positive reinforcement is often perceived to be very threatening to the traumatized child because, he perceives it to be our way of gaining power over him. When he perceives us to have the power he “knows,” his trauma (sensory memory) “knows,” he will be hurt by us. Don’t be surprised by his response to positive exchange. It will take many repetitions of these positive exchanges to build enough synaptic connections for them to become the more dominant positive response to help versus the earlier survival responses of resistance and refusal.

31. We must be genuine with our positive reinforcements but, we also must provide them far more frequently than we would normal children. If you have ever been rear-ended, you know it takes months to stop looking in your cars rearview mirror every two seconds. It takes months for the body not to tense up the moment you turn the ignition on, to not be easily startled by every strange noise. You cognitively know the odds are unlikely that you will be rear-ended again yet, your sensory memory tells you differently. Positive reinforcement must be frequent before that traumatized child's past sensory memory can become less powerful.



32. Educating the child/parent/guardian/child care worker to the differences between grief and trauma, the way they alter the brain's functions and, normalizing their many reactions within the context of trauma, is a very critical intervention to present to the significant adults in that child's life. As they learn more about the neurological impact of trauma, the

more their responses to the child's survival responses and behaviors become appropriate (deactivating rather than activating).



33. Parents/guardians/child care workers of traumatized children often have trauma histories that are likely to be activated by that traumatized child. In these cases the adults need to have trauma intervention, so as to learn new ways (sensory) to help their child survive, while deactivating their own sensory memories. When this does not happen, the traumatized adult helper will ignore their child's fears and worries, ignore their need for protection and comfort, minimize or even criticize that child's responses, which further victimize the child (secondary wounding). Educating the adult helper/guardians/child care workers and the system to the neurological impact of trauma, can help prevent further victimization of the child.

34. Working with traumatized children in groups helps

children quickly learn they are not alone, that their “problems” are not at all unusual given what they were or are continually exposed to in their lives and that they can self-regulate their reactions and responses to one another.

35. The group provides for repetitive self-regulating opportunities, which strengthen the sense of empowerment while reducing arousal and its related “survival” behaviors.
36. However, keep in mind, a group setting may be far too activating for some children, dictating the need for individual intervention.



TRAUMA INFORMED CARE IN GROUP SETTINGS

1. Conducting thorough trauma assessment at admission and throughout a child's treatment process is critical to avoiding those strategies that re-traumatize. Assessment must identify strengths as well as deficits, cognitive strengths and limitations as well as psychological strengths. There are trauma symptoms, which are not always observable, as well as sensory "iconic" memories, which children cannot describe. Trauma assessment must provide opportunities to "see" what is not observable (iconic memories) and hear what cannot be spoken.
2. All staff must be trained to distinguish trauma-related behaviors from other behaviors, the importance of distinguishing between explicit and implicit processes, the neuro-developmental impact of

trauma, the importance of titrating interventions, the body's role in healing from trauma, what is meant by "trauma as an experience" versus "trauma as a diagnostic category", why cognitive interventions are limited in their success, knowing how to become a witness to that child's experiences, the importance of being active not reactive, knowing precisely how our behavior, personality and even mannerisms can further victimize the traumatized child.

3. Trauma-informed care is not about creating a milieu the traumatized child can fit into, but allowing the child to discover those parts of the milieu that physiologically/neurologically feel the safest and then presenting the child with choices and opportunities to have access to those "parts" of the milieu.
4. Obviously we want to maintain a safe environment at all times but, for the traumatized child, what might be safe from our view is not necessarily safe from his view.
5. There is no such thing as a milieu that brings safety to every child. It is the child who brings his "safe place," "safe poise," "safe interaction" to the milieu and this is reflected in external and internal processing that often presents itself to be "problematic behavior."
6. We cannot possibly assume we know what is best for a traumatized child until we can see:
 - a) what he sees when he looks at himself,

- b) see what he sees as he looks at those around him, and
- c) what he sees when he looks at his environment.



- 7. If a child's behavior does not make sense to us, it does not mean that it does not make sense to the child. If we have to ask why behaviors are being repeated, we need to remember the experience of trauma being one where the child feels unsafe and powerless. We need to remember that all his efforts are driven by the need to survive, to find a safe place, a safe person, to feel empowered to get what he needs in his world – control. These survival responses include aggression, assaultive behaviors, avoidance behaviors, rigidity, cognitive confusion, inability to follow directions, basic flight, fight and freeze responses.

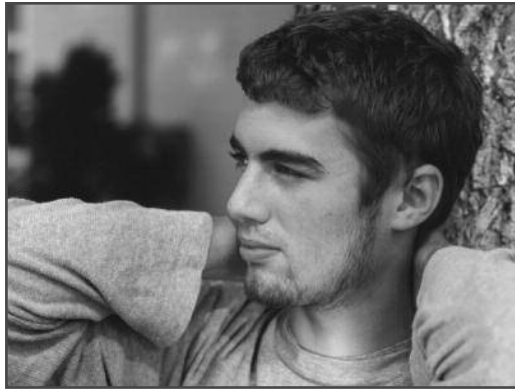
- 8. Trauma surviving says, "I must do something to let you know I'm terrified...I will do whatever I need to do to control you and control your responses in

order to survive...I will fight any experience, any activity, any person that I see as a threat to me...any person that tries to "control" me because if I let you control me I am vulnerable to your abuse, abandonment, again and again..."

9. To the traumatized child we can be perceived to be a real physical (safety) threat, therefore he either avoids us (flight) at all cost or he strikes out assaultively or becomes oppositional (fights) in hopes of gaining power over us. We can be perceived not as a physical safety threat but a threat to keeping him from what he wants. When this is his perception he will then engage in a wide variety of behaviors to control our actions/interactions with him.
10. We can be perceived to be no threat at all and as someone the child can get whatever he wants from, whenever he wants. He sees us as easy to manipulate and does.
11. And then we can be perceived to be of no use to him.
12. To eventually be in the position to give that child new sensory experiences that diminishes the old trauma sensory memories and allows him to experience a restoration of that sense of safety and power, we must become the an influential individual in that child's life.



13. To be influential, not controlling (avoiding power struggles), we must, a) be a safe person to be with, b) be in control of our emotions, c) provide clearly expressed expectations to that child, d) daily demonstrate our confidence in that child, that he can master new experiences and relationships and, e) consistently follow through. In agency settings, traumatized children can often spend the majority of their time with adults who themselves have experienced trauma and are easily activated. These are the adults that children perceive to be either a physical/safety threat, easily manipulated. These are the adults who will find it difficult to consistently engage the previously describe criteria for establishing influence until they learn to regulate their own survival responses.
14. If traumatized children are viewing us and their environment as a threat, we need to engage sensory interventions to replace that trauma sensory view.



15. Although engaging sensory activities to calm an aroused child is the intervention of choice, in no way will this prevent the repetition of future arousal responses.
16. To reduce these arousal behaviors we must alter the traumatic sensory memories by changing the child's "iconic" (sensory) identity of self as powerless and unsafe. Once we can restore that sense of safety a reduction in trauma symptoms and trauma related behaviors begins to take place.
17. Trauma symptoms and related behaviors are driven by sensory memories; not reason, logic, and executive functions. "I am driven by my iconic representation of me" (a victim, powerless, vulnerable, at no time safe).
18. The traumatized child's body will quickly recall those physiological, emotional manifestations of terror, of feeling unsafe and powerless when elements of the environment and people's actions trigger these

memories. Therefore, we need to know as much as possible about the details of those experiences to identify what elements, behaviors and environmental factors may activate the child.

19. The child's behavioral response to these activating triggers in the past may have protected him, he may have run out of the house. Running can be construed to be truant, uncontrollable or impulsive behavior. However, for the child it is behavior that worked in the past and kept him safe. Knowing this, we must then help the child find other acceptable (escape) behavior(s) when he feels threatened.

20. The first step in changing behavior is to teach the child he can regulate the physiological and emotional reactions activated by a threat by using his body as a resource. Traumatized children need to constantly be directed to their body's response during stressful difficult times as well as during relaxing periods (safe periods). They need to be taught how to control the physiological manifestations of arousal by inducing the physiological manifestations of safety. It is a skill that must be repeated many times, until the child becomes confident that he can call upon this resource at any time.

21. However, this is only the first step to helping the child find relief from his tenacious, iconic and sensory trauma memories. These must be diminished by the repetitive sensory experience of self as a sur-

vivor and thriver. This can only be accomplished through trauma focused sensory interventions and opportunities and later confirmed by cognitively reframing those thoughts about self and life he has experienced at a sensory level.

22. Finally, it is critically important that systems overseeing the care of traumatized children also become witnesses to what life is really like for the child. Systems cannot be held accountable for supporting appropriate services and resources until they can see the child and his experiences in the same “sensory” way we as trauma specialists experience that child’s view of self, others and his environment.



CONCLUSION

If the lessons learned presented in this paper are not the footing and foundation that supports our interventions with traumatized children there will be little change in the way we interact with the children. TLC's evidenced based research has clearly documented, without question, the remarkable, outstanding, statistically significant gains that traumatized children can see when we meet them in their sensory world whether that be in individual sessions, group sessions, schools, agencies, residential settings (Steele, Raider & Kuban, 2009; Steele, Raider, Delillo, Jacobs & Kuban, 2008). It is not the setting that brings about these changes but, focused, sensory based trauma interventions that initiate new management of those past experiences through the help of trauma informed staff capable of supporting the trauma principles just presented. For further information about TLC's evidenced based intervention programs and certification for Trauma and Loss Specialists do contact us toll-free at 1-877-306-5256 or visit our website at www.starrtraining.org/tlc

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TLC RESOURCES

TLC's mission is to provide accessibility to evidence-based trauma intervention and trauma specific resources those who work with traumatized children and families. We offer Trauma and Loss Certification, trauma training, online courses, trauma interventions, books, DVDs, and a wide range of resources for parents as well as professionals.

TLC CORE TRAUMA TRAINING COURSES:

Children of Trauma

A thorough explanation and demonstration of TLC's evidence based, structured sensory trauma intervention process and strategy. Three levels of intervention are presented along with timelines for their intervention. Videotaped interviews demonstrate the process and set the foundation for the use of all TLC school and community based and researched programs.

Structured Sensory Interventions (SITCAP)

SITCAP is the acronym for Structured Sensory Interventions for Traumatized Children, Adolescents and Parents. This follow-up day to Children of Trauma is a day of practice. Participants move through actual activities, which make up the above intervention programs covering children and adolescents 3-18 years of age as well as adults. Participants have the opportunity to experience first hand what the sensory process accomplishes. All questions about the process – the how, when, where, with whom, when not to – are answered. Following this day participants will be able to use any of the SITCAP programs.

Trauma Debriefing for Schools and Agencies

The TLC Debriefing Program fits well with the uniqueness of a school or agency setting. There are five models within the Program, including:

(1) Debriefing for adults and adolescents, (2) Defusing for K-5th grade, (3) Debriefing for the debriefers or crisis response team, (4) Operational debriefing for entire staffs, and (5) Classroom or group presentations. These five models address the developmental needs, possible time and resource constraints, needs of students or clients and staff, administrative issues, and caregiver and community needs.

Additional courses and trainings available.

TLC ONLINE COURSES:

6 Credit Hour TLC Online Courses

TLC online courses provide professional CEUs. Some courses include books. We continue to add new courses, so keep checking the TLC website at www.tlcinstitute.org for additional offerings.

- ✓ Adolescent Grief
- ✓ Art, Play, Music, Drama & Bibliotherapy: Advanced Skills
- ✓ Bullying and Cyber Bullying
- ✓ Confronting Death in the School Family
- ✓ Domestic Violence
- ✓ Eating Disorders and Trauma
- ✓ Ethics of Art and Play Therapy
- ✓ Pain Management
- ✓ Psycho-Physiology of Trauma
- ✓ Reaching and Teaching Stressed and Anxious Students
- ✓ Resilience and Posttraumatic Growth in Children
- ✓ Suicide Intervention
- ✓ Trauma Informed Assessment and Practice
- ✓ Trauma Informed Schools
- ✓ Working Through an Ethical Lens
- ✓ Zero to Three: Trauma Intervention
- ✓ Essay Exams

For additional information call TLC toll-free at 877-306-5256

or visit our web site at www.starrtraining.org/tlc