IDAHO SOCIETY OF INDIVIDUAL PSYCHOLOGY

Healing Trauma through Connection

An Adlerian Integrative Perspective

with

Anthea Millar

March 5 & 6 2021

Trauma: An Adlerian Perspective Extracts from Millar, A. (2013) JIP

The moment of a major traumatic event can perhaps be summarised as the ultimate experience of inferiority from which individuals attempt to maintain well-being through "an oversized safeguarding component" (Adler 1956).

Adler's holistic understanding of the person's need to find creative solutions to safeguard and overcome feelings of inferiority and insecurity in order to meet the essential need both to belong and to strive towards meaning has stood the test of time with his theories being confirmed in contemporary psychological researches.

Traumatic events are well captured by Herman (1992) when she writes that they "… overwhelm the ordinary systems of care that give people a sense of control, connection and meaning" (p. 33). Similarly Adlerians O'Connell and Hooker (1996) identify those with Post Traumatic Stress Disorder (PTSD) as having "been faced with experiences that have shattered their sense of personal identity, worth and belonging" (p. 180).

"Control, connection and meaning" and a "sense of worth and belonging" are central to an Adlerian understanding of what is crucial to all humans for their survival. Lew and Bettner (1996) have identified this in their model of the Crucial Cs, when they describe the essential need for all of us to Connect, feel Capable, and to Count, and a fourth crucial "C", "Courage", which enables us to handle challenges in a positive and socially constructive manner.

However, when there is an intense experience of helplessness and terror, our everyday safeguarding processes and accompanying courage become overwhelmed and disorganised. It is not the objective facts that determine whether an event is traumatic, but our ***subjective emotional experience*** of the event. The more frightened and helpless we feel, the more likely we are to experience feeling traumatised.

Drawing on Adlerian psychology, Ilan Stauch offers a reconceptualisation of trauma and Lifestyle as follows: *'As long as the traumatic event remains unintegrated with the Lifestyle, it will be re-enacted in various situations, and it will affect a person's psychological movement and interactions, essentially becoming a psychological tumor…….Just as a physical tumor may interfere with an organism's functioning and may divert or prevent nutrients from providing nourishment as needed, a psychological tumor (trauma) will divert a person's goal directedness either in content or method'. Strauch (2001 p. 252)*

Trauma impacts primarily on the body as well as the mind. Understanding the physiology as well as the psychology of trauma is crucial in therapy. Highly traumatised and chronically neglected /abused people may be dominated by immobilisation and metabolic shutdown, whilst those acutely traumatised without complex histories may more commonly experience the 'fight' and 'flight' responses. Adler stated:

> *Every biological, psychological and social aspect of the individual is dynamically and systematically connected. …tension is communicated to the whole body…through the autonomic nervous system, the vagus nerve, and endocrine variations…..' Adler 1956 p 224*

Adlerian Psychology and practice offers hope. Traumatic events are unfortunately part of human existence, however, we have remarkable adaptability and resilience in our striving to overcome adversity – and our potential for re connection with Gemeinschaftsgefühl (Community feeling), finding expression in even the darkest of places.

Some Trauma Definitions

"… experiences that overwhelm the ordinary systems of care that give people a sense of connection, control and meaning". (Herman 1992)
"….having been faced with experiences that have shattered their sense of personal identity, worth and belonging" (O'Connell and Hooker 1996)

Distinguishing between different types of trauma:

Type 1 Single Shock Trauma:

Refers to either one single event – such as a car accident, a single occurrence of sexual assault, a terrorist incident or a physical assault. This type of trauma often leads to no long-term psychological difficulties but in around 25 to 30 per cent of cases persists to meet the criteria for a diagnosis of post-traumatic stress disorder (PTSD) (NICE, 2005).

Common Experiences:

- Intrusion of distressing memories – flashbacks
- Avoidance of distressing memories thoughts and feelings
- Alterations in cognitions and mood – dissociative amnesia – negative beliefs – shame
- Alterations in arousal and reactivity

Type 2 Trauma:

Consists of multiple traumatic events over a period of time.
Known as **Complex Trauma, Interpersonal Trauma or Developmental Trauma.**
The more serious impacts arise from either the cumulative impact of multiple forms of interpersonal trauma, or any one form of abuse that leads to an ongoing sense of powerlessness.

Complex Trauma:

Consists of repeated, often multiple forms of abuse – physical, sexual and/ or emotional. It also can arise in the context of extreme neglect.

Complex trauma is **interpersonal** in nature – it is harm that occurs in the context of relationships and impacts on a child's or person's capacity to develop positive future relationships. This is crucial in understanding how we can help people with complex trauma. It is often interpersonal difficulties between clients and professionals that get in the way of help; for example, when clients make sporadic engagement with practitioners or 'dis-engage' altogether.

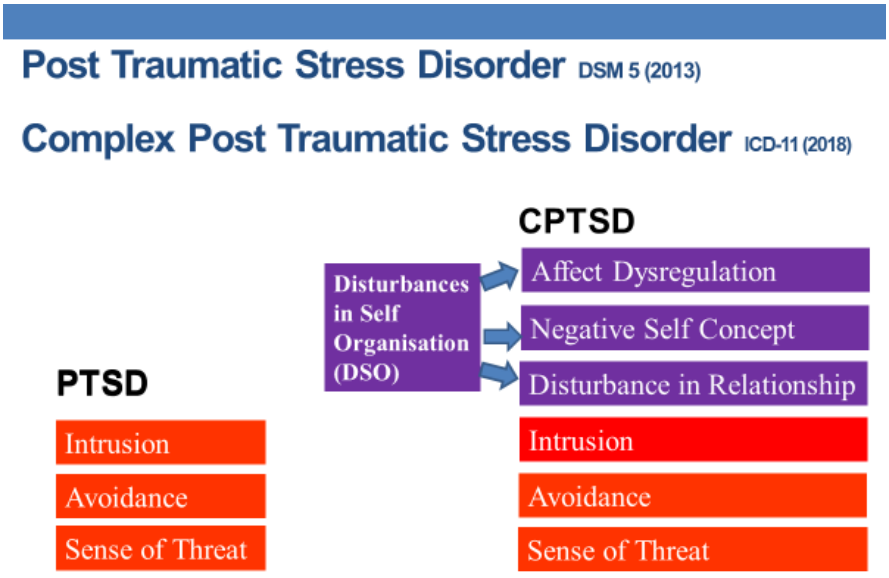
Common experiences (in addition to those described in Type 1 trauma):

- Impairment in regulating affective impulses
- Chronic self-destructive behaviours: self-harm, eating disorders, substance abuse
- Alterations in attention and consciousness, dissociative episodes, 'spaciness'
- Alternations in self-perception – chronic guilt, shame, over responsibility, negative self-view,
- Alterations in relationships with others –challenges with emotional intimacy, fear of rejection, abandonment, criticism
- Medically unexplained symptoms of diffuse somatic pain: eg headaches, abdominal / joint / muscle pain
- Alterations in systems of meaning – sense of hopelessness, despair

DSM 5 and ICD 11

Due to the significant differences between single event and multiple prolonged trauma, proposals have been made for a separate category of **Complex Traumatic Stress disorder** (Herman 2006) or **Developmental Trauma Disorder** (van der Kolk 2014). These differences were not taken into account by DSM 5 (2013) despite considerable evidence that 'Survivors of prolonged abuse develop characteristic personality changes, including deformations of relatedness and identity…'(Herman 1992 p379).

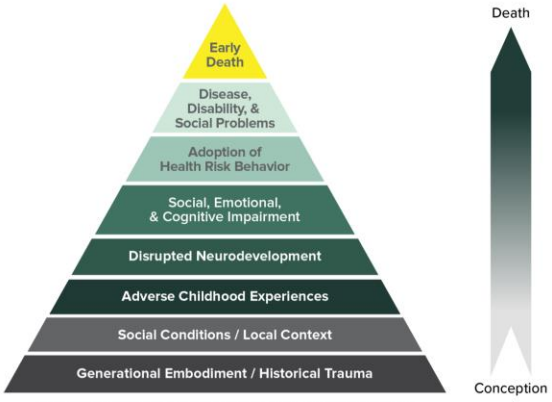
ICD 11 (2018) does attempt to identify complex trauma: 'A delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone….that may follow a chronic course over many years'.



Adverse Childhood Experiences Study (ACEs)

This was one of the largest investigations ever to assess the association between childhood maltreatment and later health and well-being. In the 1980s Dr Vincent Felliti noted a high drop-out rates in his obesity clinic, despite evidence of significant weight loss and came upon a link between the development of obesity and childhood sexual abuse. With Dr Robert Anda, they undertook a major study (17,500 people) exploring the association between childhood experiences and health throughout life. They were asked about their health history as well as their childhood experiences, specifically asking about adverse experiences that included emotional, physical and sexual abuse and neglect. (Felliti et al, 1998)

The more ACEs experienced by an individual in childhood, the greater the seeming risk of developing a range of mental, social and physical health issues as an adult. Those who had experienced 4 or more ACEs were seen as more likely to experience health problems (heart and lung disease, cancer), engage in health risk behaviours (eg Drug use, suicidal ideation), or to have experienced or perpetrated violence and to have been in prison.



Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Adverse Community Experiences

Adler clearly identified through his holistic approach and understanding of our social embeddedness, that no individual, and no family, exists in a vacuum. He stated:
'The honest psychologist cannot shut his (or her) eyes to social conditions which prevent the child from becoming part of the community and feeling at home in the world, which allow him to grow up as though he lived in enemy country…..the psychologist must work against nationalism…….against unemployment which plunges people into hopelessness; and against all other obstacles which interfere with the spreading of social interest in the family, the school, and society at large' (Ansbacher 1956 p 454)

The original ACES study has been criticised for omitting discussion of such deeply embedded social injustices and power imbalances around **racism, poverty, forced displacement, homelessness or community violence,** and the significant impact on the health and wellbeing of whole communities and the individuals who experience these.

Critique of a Medical Diagnostic Approach

Adler's emphased the importance of unity and self- creativity, and particularly how the use of classification into narrow typologies around mental health can mean a loss of understanding of a person's unique attitude to life. Adler (1935) expresses this concern eloquently:

'I believe it is because of parsimony of language that many scientists have come to mistaken conclusions—believing in types, entities, racial qualities etc……To present the individual understandably, in words, requires an extensive reviewing of all of his facets……Yet, too often, psychologists are tempted away from this recognition, and take the easier but unfruitful roads of classification'.

'Diagnostic criteria relating to trauma, in ICD-11 and DSM 5, are presented as lists of symptoms with no attempt at understanding the mechanisms of trauma, or at seeing them in the context of human biological and social systems. This seriously limits their usefulness to the psychological therapist'. Guilding 2020

Power Threat Meaning Framework Johnstone and Boyle, 2018

- *Moving beyond the 'DSM mindset'*
- *A framework for understanding people in their **social and relationship contexts**…which sees them as **actively making choices and creating meaning in their lives**, within inevitable bodily, material, social and ideological constraints*

Not 'What is wrong with you?' – instead:

- What has happened to you? How is **Power** operating in your life?
- How did it/does it affect you? What **Threats** does this pose?
- What sense did/do you make of it? What **Meaning** do you make of these experiences?
- What are you doing to survive? What kinds of **Threat** responses are you using?
- What are your strengths? What access to **Power** resources do you have?

'What will now support you towards becoming cooperative, responsible, and contributing member of the community?'

What is Trauma Informed Care? Ref SAMHSA 2014

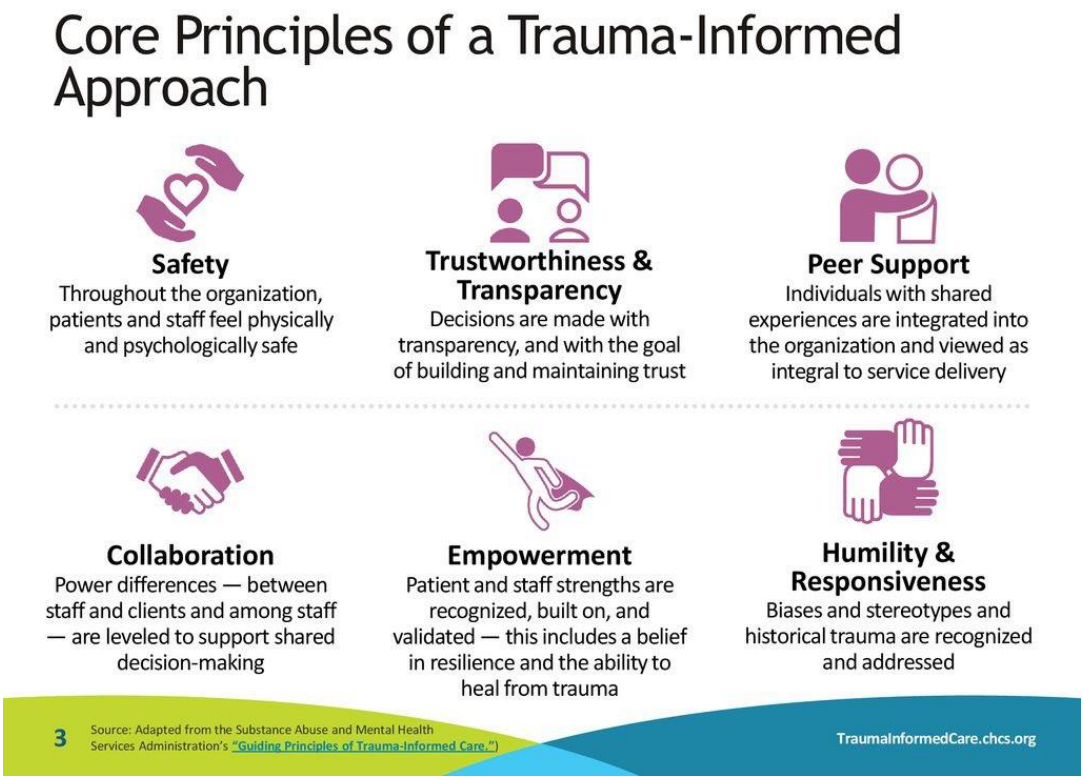
'A program, organization, or system that is trauma-informed……..

***realizes** the widespread impact of trauma and understands potential paths for recovery;*

***recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and*

***responds** by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively*

***resists** re-traumatization'. SAMHSA 2014*



Safeguarding Purpose of Trauma Symptoms

Extracts from Millar, A. (2017)

In Adlerian terms the impact of severe trauma can be understood as the ultimate experience of inferiority, from which we attempt to maintain our well-being by "an oversized safeguarding component" (Adler, as cited in Ansbacher & Ansbacher, 1956, p. 263).

Children who have experienced prolonged adverse events in childhood or adolescence and who act out their distress may be diagnosed with such labels as 'oppositional defiant disorder', 'attachment disorder', 'conduct disorder'. In later adulthood the personality disorder labels may be applied freely: 'Borderline Personality Disorder' (BPD) being one such common diagnosis. In an important early study undertaken by Herman, Perry and van der Kolk (1989) it was revealed that 81% of people diagnosed with BDP in one hospital reported severe histories of child abuse and neglect.

In addition to the dangers of applying fixed character traits on a person, diagnostic labelling gained from symptom assessment ignores the purpose of the behavior. The Adlerian approach offers a frame of understanding so we can appreciate how much disturbing behavior is actually about a person's attempt to safeguard themselves against a sense of disconnection and fragmentation – both rage and withdrawal being aspects of a whole range of desperate purposive attempts to compensate for an ongoing perception of loss of belonging.

Holism: Mind and Body Connection

The need for safety and connection is so fundamental it is deeply based in our body's functioning, as identified in Adler's holistic approach:

The individual is 'indivisible' and needs to be understood holistically, every biological, psychological and social aspect of the person being dynamically and systematically connected.
From the first days of life, uninterruptedly till the end, this partnership of growth and development continues...body and mind cooperate as indivisible parts of one whole.' Adler (1980 p 27)

Organ Jargon

A further important aspect of this holistic approach can be seen in Adler's use of the term 'Organ Jargon'. In a seminal paper entitled "Physical manifestations of psychic disturbances", Adler (1934/1964) put forward the view that individuals express themselves through their organ systems (endocrine, cardiovascular, musculoskeletal, and nervous systems), with every organ capable of expressing emotions and physical symptoms.

As Adler identified, connecting mind and body is crucial, and in trauma therapy, we need always to keep the body's physiology in mind. The work of Stephen Porges (2011), with his Polyvagal theory of emotion, offers an invaluable new frame for understanding the psycho-physiology of responses to traumatic events, further clarifying our need for social connection, and the major challenges that arise when this is not met.

The Polyvagal Theory Stephen Porges 2017

The Polyvagal Theory offers a developed understanding of the biology around safety and danger, taking it beyond the effects of fight and flight and putting ***social relationships*** right at the centre of an understanding of stress and trauma. ***Polyvagal theory emphasises that the need to connect is a primary biological imperative for humans. Through connectedness, physiology is co-regulated to optimise mental and physical health.***

Polyvagal refers to the many branches of the long vagus nerve which has evolved over millions of years. The more recently evolved 'new' myelinated **ventral vagus** optimises oxygen via heart and lung activity and links to other nerves to engage our sense of hearing and enhance our neck, jaw face and throat muscles. The old unmyelinated **dorsal vagus** immobilises us.

Porges clarifies that the Autonomic Nervous System regulates **3 fundamental physiological states (not just 2 as in traditional views).**

When we perceive threat, if we are able, we go to the most recently evolved level:

1) **Social Engagement: (Ventral Vagus)** in this level we check what's happening, we are able to call for support, and help and find comfort from those around us.

If this fails (for example if no one comes to our aid) we will perceive the situation at a higher status of danger and we go to the second more primitive level:

2) **Fight or Flight: (Sympathetic System)** we mobilise – either to fight off our attacker or to run away to somewhere safe.

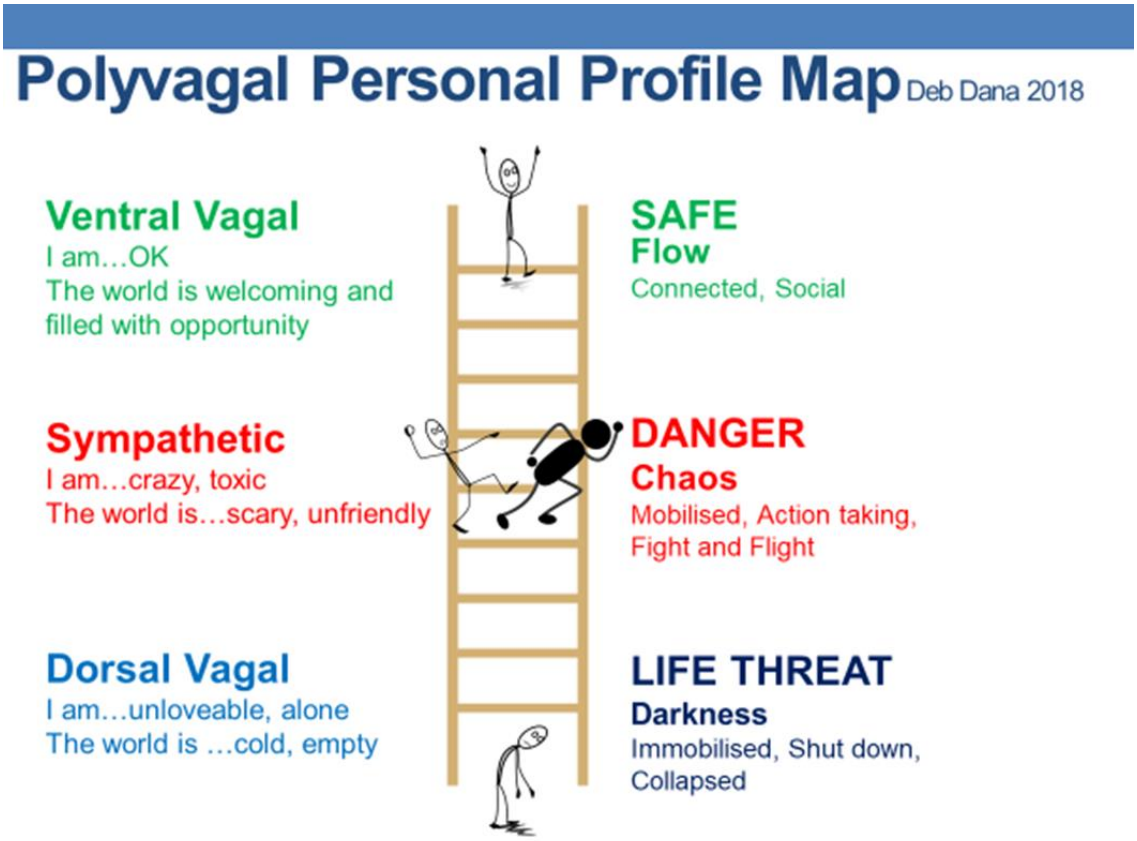
A very young child cannot usually protect themselves by fighting or fleeing. So finding safe connection and social engagement is crucial for a future sense of well-being and security.

If mobilisation fails, and we can't get away, eg if we're held down or feel trapped – we may try to preserve ourselves by our most primitive survival system:

3) **Immobilisation: (Dorsal Vagus)** we shut down and expending as little energy as possible. This may result in a **freeze** state, or develop on to a **faint or collapse**. This survival system of 'playing dead', being 'scared to death' creates immobility, shutdown and dissociation. The challenge here is that this very survival response suppresses our social connection system.

This immobilisation response evolved as a means of a brief survival mode for acute situations. However highly traumatised and chronically neglected or abused individuals with developmental trauma experiences are commonly dominated by the immobilisation / shutdown system. They are also commonly plagued by dissociative symptoms, such as a sense of unreality, depersonalisation and various somatic and health complaints such as gastrointestinal problems, migraines, persistent pain, and chronic fatigue.

Daily Movements on the Polyvagal Ladder



We all move up and down the autonomic ladder.

The ventral vagal state is hopeful and resourceful. We can live, love, and laugh by ourselves and with others. This is not a place where everything is wonderful or a place without problems. But it is a place where we can acknowledge distress and explore options, be creative, reach out for support and develop organised responses. We can be open to new vistas and do not need to react with private logic thinking.

We move down the ladder into action when we are triggered into a sense of unease—of impending danger. We hope that our action taking here will give us enough space to take a breath and climb back up the ladder to the place of safety and connection. We will resort to well-worn patterns of our Lifestyle and private logic

It is when **we fall all the way down to the bottom rungs** that the safety and hope at the top feels unreachable. This is what Adler named the ultimate sense of inferiority.

Exercise

Adapted from: Deb Dana (2018) The Polyvagal Theory in Therapy: Engaging the Rhythm of Regulation.

Consider how your autonomic system might respond to each point on the ANS ladder.

Identify what you find yourself **THINKING, FEELING and DOING** in each state

What are the core beliefs/ private logic / story in each state:

Ie: I am, the world is, others are, therefore I….

- **My dorsal vagal system** takes hold when I……..

(Eg: I don't matter, am without options; I feel trapped, lost, helpless; others have the power therefore I shut down, collapse)

- **My sympathetic nervous system** kicks in when I……..

(Eg; am pressed for time; am ignored; am confused; am pushed to make a choice or take a side; am around conflict, feel responsible for too many people and too many things)

-
- **My ventral vagal system** comes alive when I

(Eg: Think about people who are important to me; am out in nature; give myself permission to make my own choices; listen to music; enjoy quiet time with my pet; have my feet in the sea; stand under the stars; share a cup of tea with a friend)

Dissociation ref: Boon, Steele and van der Hart (2011) and http://www.isst-d.org

Dissociation is **an adaptive safeguarding survival response** when a person feels threatened, allowing the mind or body to split off or compartmentalise traumatic memories from normal consciousness.

To understand dissociation, it is helpful first to understand its opposite: **integration.** Integration can be understood as the organisation of all the different aspects of the personality (including our sense of self) into a unified whole that functions in a cohesive manner. In Adlerian terms, this is our Lifestyle: 'My thoughts, behaviours, emotions, sensations and memories, no matter how pleasant or unpleasant all belong to me'.

Dissociation is a loss of integration that interferes with our sense of self and our personality. It describes the disconnection or lack of connection between things usually associated with each other. Trauma can chronically impair our integrative capacity. It can also be impaired when we are extremely tired, stressed and seriously but in these cases the disruption is temporary.

In severe forms of dissociation, disconnection occurs in the usually integrated functions of consciousness, memory, identity, or perception. For example, someone may think about an event that was tremendously upsetting yet have no feelings about it, an emotional numbing, one of the hallmarks of post-traumatic stress.

Cues to Dissociation:

- Facial features: eyes unfocused, waxy, blank, glazed look
- Inability to speak, numb with terror, prolonged silence, avoidant, sense of helplessness
- Robotic language – repetitive phrases
- Long monologues with no reflection or mentalisation
- Changes in narrative – unfocused, disorganised, incoherent
- Somatic cues: jerky movement, changes in temperature, freezing
- Entering parallel worlds – fantasy 'beautiful and benign' vs reality 'terrifying hostile world
- Submissive, compliant 'good' client.
- Switching between submission and hostile aggression

Dissociative Identity 'Disorder'

A client with dissociative identity 'disorder' (DID), at some point during therapy, will invariably present with their 'alternate personalities', otherwise known as 'alters', 'parts' etc. These may present as having different ages, a different gender, different characteristics and often different levels of awareness of their autobiography. Some will be aware of or 'co-conscious' with other 'parts' of the personality, whilst others will not: when there is no co-consciousness, there will often be brief amnesic blanks when that part is 'out' or 'in executive control'. This can be distressing and worrying for the client, who may feel that they are 'going crazy' as they do not know what they have done or said during the preceding period of minutes, hours, or (rarely) days.

It is important to bear in mind that the parts are not actually separate identities or personalities in one body, but rather parts of a single individual that are not yet functioning together in a smooth, coordinated, and flexible way. Adler's holistic concept of the unity of the individual is clear here.

The ultimate work of therapy is to facilitate an increased coordination between these parts, so that they can indeed function together and perhaps even merge or 'fuse'. By working on increased communication and cooperation between parts, often there is a corresponding increase in levels of co-consciousness, which can help the client to feel in much better control of their life.

Internal Family Systems Therapy (IFS) **Richard Schwartz.**

ref: Anderson, Sweezy and Schwartz 2017

IFS addresses multiple parts or families within each person's mental system.

1. Exiles

Revealed in feelings, beliefs, sensations and actions, these parts have been shamed, dismissed, abused or neglected and are subsequently banished by 'Protectors' for their own safety, in order to keep them from overwhelming the internal system with emotional pain. A great deal of internal energy is expended to keep exiles out of awareness.

2. Protectors

Proactive Protectors: 'Managers'

Focus on learning, functioning, being prepared and being stable. Are vigilant in trying to prevent exiles fro being triggered and flooding the internal system with emotion. They work hard using a variety of tactics – relentless, criticising and at times shaming – to keep us task oriented and impervious to feelings.

Reactive Protectors – 'Firefighters'

Like the Managers, they wish to exile vulnerable parts and extinguish emotional pain, but they do this as emergency response workers. Tend to be fierce, and use extreme measures like alcohol and drug use, excessive shopping, promiscuity, cutting, suicide and even homicide.

The Self

This is the innate presence in each of us that brings balance and harmony along with certain non-judgemental, transformative qualities **(curiosity, caring, creativity, courage, calmness, connectedness, compassion**). Whilst parts can obscure the Self, it continues to exist, and is accessible as soon as the parts no longer dominate and can separate/unblend.

Phases of Trauma Therapy: Janet 1898 , Herman 1992

1) Stabilisation and Safety: The most essential phase, often given too little attention. In complex cases, this might be the only phase appropriate for therapy.

2) Remembrance and Mourning: Processing trauma memories – However it is inadvisable to move too quickly to phase 2 until many of the goals of phase 1 are achieved

3) Integration: This phase woven into phases 1 and 2 – need to integrate the therapy work into lives outside therapy. Building a positive sense of self and the world

Principles of Safe Trauma Informed Therapy

1) Identify and name the problem. Give HOPE. Name their experience and provide psychoeducation to alleviate the frightening 'wordlessness' of the symptoms. Identify the commonality of symptoms discovery that is not alone - that there is recovery -

2) Provide and ensure Safety (physiological and psychological)- Trauma survivors commonly feel unsafe in their bodies, in their emotions, thinking and with other people. Therefore therapy needs to address these, exploring ways for the person to bring some sense of control.
Enable ***Dual attention*** at all times. DO NOT work on trauma memories until there is some stabilisation: ensure client can **'apply the brakes' or 'turn off'** traumatic memories.

3) Maintain a positive therapeutic relationship. Good contact between therapist and client is prerequisite to addressing traumatic memories or applying any techniques - even if that takes months or years. The therapist must be prepared, at times, or even for a whole course of therapy, to put aside any and all techniques and just "be" together with the client.

4) Tailor the therapy to the client –adapt and pace processes to needs of client. A broad knowledge of theory - both psychology and physiology of trauma - reduces errors and allows the therapist to create processes and techniques tailored to a particular client's needs.

5) Work on Reconnection – building trust with others – connection with the community – Enable the client to discover they are not alone. Trauma survivors need to find their own control, reconcile with themselves, and shed the victim role, in order to move towards constructive social relations.

6) Be aware of deeply embedded socio-cultural issues (racism / sexism / political imprisonment / torture / gender discrimination etc.) PTSD is primarily an Anglo-European diagnosis. Move from medical diagnostic process and work to understand the meaning of the experiences in a power threat context.

7) Monitor the dynamics and possibility of vicarious traumatisation. The therapist needs to be aware of his/her/their own issues around trauma - what are your ways of handling trauma / stress in your own life? Is there a pattern of avoidance of pain? Regular supportive supervision & consultation is really important when working with trauma.

Assessing Types of Trauma the Client is Experiencing

Ref: Lenore Terr (1994), Babette Rothschild (2000) 'The Body Remembers' pp80-81

It is important to determine which type of trauma and which type of trauma client you are dealing with, in order to make a therapy plan.

Type 0 Either has never experienced trauma OR has no traumatic events impacting on the Nervous System. Trauma therapy for this type of client is irrelevant and potentially dangerous.

Type I Has experienced a single traumatic event only OR has had multiple traumas but only one is now impacting on the Nervous System. It is likely that Phase 1 is needed for less time. This client is a good candidate for addressing trauma memories(Phase 2).

Type II Multiple traumas are still active in the Nervous System.
Two subtypes

- **Type IIA -** clients with multiple traumas who have stable backgrounds that have sufficient resources to separate the individual traumatic events from each other. They can speak about each one at a time, and so can address each one at a time.

These clients may be able to work at Phase 2. However stability is crucial before moving on to Phase 2 as the client will have developed further safeguarding/defence mechanisms, and addressing traumas will loosen these safeguarding mechanisms.

- **Type IIB** – clients who are so overwhelmed by multiple traumas that they are unable to separate one traumatic event from another. This client may talk about one trauma and then quickly find links to others. Their traumatic past merges into one. Boundaries are poor and resilience much less.
  These clients are NOT good candidates for Phase 2 as can rapidly become decompensated. However with longer term work, they may move to IIA Type.

  Type IIB have 2 further sub categories:

  Type IIB(R) Clients with a stable background, but with a complexity of traumatic experiences so overwhelming that can no longer maintain resilience(R). (eg Holocaust survivors).

The therapeutic relationship will help reacquaint the client with the resources they knew but have lost touch with due to the overwhelming nature of the trauma.

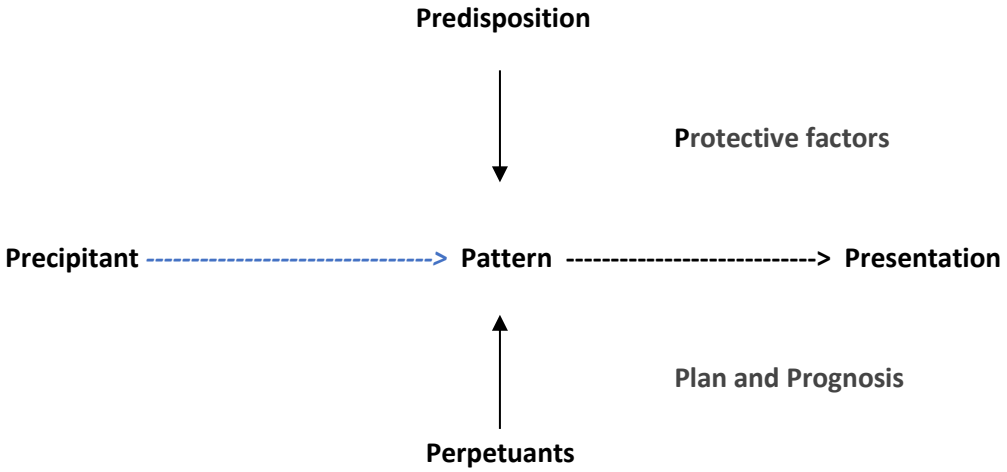
Type IIB(nR) Clients who never developed resources for resilience.

Building the therapeutic relationship and work on facilitating boundaries, resources and resilience may be the whole of the therapy.

Case Conceptualization Len Sperry & Jon Sperry 2020

Len and Jon Sperry (2020) have created a valuable model of case conceptualization, describing 8 key elements all beginning with P, to help understand the client holistically and non-pathologically:

- **Presentation:** description of the nature and severity of the client's clinical presentation. Typically, this includes symptoms, personal concerns and interpersonal conflicts.
- **Predisposition:** refers to all factors that contributing to their present situation, which usually involve biological, psychological, social and cultural factors.
- **Precipitants:** refer to physical, psychological and social stressors that may be coinciding with the onset of the difficulties, such as trauma, pain, medication side effects or withdrawal from an addictive substance.
- **Protective factors and strengths**: this could include coping skills, a positive support system, a secure attachment style and the experience of leaving an abusive situation. These are often the mirror opposite of risk factors. Related to protective factors are strengths. These enable individuals to think and act in ways that benefit themselves and others. Examples of strengths include mindfulness, self-control, resilience and self-confidence.
- **Pattern:** refers to the predictable and consistent style or manner in which an individual thinks, feels, acts, copes, and defends the self both in stressful and nonstressful circumstances. (In Adlerian terms we might call this Lifestyle). Pattern has physical, psychological and social features, also including the individual's functional strengths, which counterbalance dysfunction.
- **Perpetuants:** refer to processes through which an individual's pattern is reinforced and confirmed by both the individual and the individual's environment. These processes may be physical, psychological, or social.
- **Plan (**for the therapy work), refers to a planned therapy intervention, including treatment goals, strategy, methods and ethical considerations.
- **Prognosis:** refers to the individual's expected response to treatment. This forecast is based on the mix of risk factors and protective factors, client strengths and readiness for change, and the counselor's experience and expertise in effecting therapeutic change.



Ref: Sperry and Sperry (2020)

Stabilisation and Safety

Learning to 'put on the brakes' Ref: Judith Herman (1992) Babette Rothschild (2000, 2017) Bessel van der Kolk (1996) Peter Levine (1997)

'I have increasingly found the trauma therapy default mode - to process trauma memories – to be outdated and overrated. Why have therapists been taught to head first for ***trauma memories*** when it is ***recovery from trauma*** that our clients are seeking? Trauma recovery includes:

- Understanding that a traumatic incident is over, and in the past
- Freedom from, or good-enough management of symptoms, including flashbacks and dissociation
- Reestablishment or significant improvement of quality of life' Rothschild 2017 p.11

There can be a danger in addressing traumatic material before the client is equipped to manage it. It is like being taught to drive and to hit the accelerator without having learned to apply the brakes. Therefore before asking clients about their memories, we need to be confident that the flow of anxiety, emotion, memories and body sensations can be contained at will. (Rothschild 2000)

Developing 'trauma brakes' will enable the help to feel safer, the clients to feel they are in control and in the driver's seat. This can enable them to dare go deeper if appropriate.

Some fundamentals for Safe Trauma Care

1.**Establish safety and stabilisation for the client.** – offer grounding strategies and psychoeducation to help them understand their experiences.
2. **Become familiar with the physiology of stress**. Keep a careful eye on the client's physiology to ensure they are not triggered, hyperaroused or dissociated.
3. **Ensure a stable base and a positive relationship** is developed before considering addressing traumatic memories .
4. **Client and helper must be confident in applying the 'brake'** before using the 'accelerator'.
5. **Identify and build on client's internal and external resources**. Understand 'defences' as safeguarding strategies and regard them as resources. Don't 'get rid' of coping strategies but create more choices.
6**. Acknowledge the client with his/her/their own individual differences**. Never expect one intervention to have the same result with all clients.

Noting the Physiology of Stress/Trauma

Babette Rothschild 2016

AUTONOMIC NERVOUS SYSTEM: PRECISION REGULATION – Ref Babette Rothschild 2016

	LETHARGIC Parasympathetic I(PNS 1)	**CALM** Parasympathetic II(PNS II) Ventral Vagus	**ACTIVE/ALERT** Sympathetic I (SNS I)	**FLIGHT/FIGHT** Sympathetic II (SNS II)	**HYPER FREEZE** Sympathetic III (SNS III)	**HYPO FREEZE** Parasympathetic II(PNS II) Dorsal Vagus
PRIMARY STATE	**Apathy, Depression**	**Safe, Clear thinking Social Engagement**	**Alert, Ready to act**	**React to Danger**	**Await opportunity to escape**	**Prepare for Death**
AROUSAL	**Too low**	**Low**	**Moderate**	**High**	**Extreme Overload**	**Excessive Overwhelm Induces Hypoarousal**
MUSCLES	Slack	Relaxed/Toned	Toned	Tense	Rigid (deer in headlights	Flaccid
RESPIRATION	Shallow	Easy, often into belly	Increasing rate	Fast, often in upper chest	Hyperventilation	Hypo-ventilation
HEART RATE	Slow	Resting	Quicker or more forceful	Quick/and/or forceful	Tachycardia (very fast)	Bradycardia (very slow)
BLOOD PRESSURE	Likely low	Normal	On the rise	Elevated	Significantly high	Significantly low
PUPILS, EYES, EYE LIDS	Pupils smaller, lids may be heavy	Pupils smaller, eyes moist, eyelids relaxed	Pupils widening, eyes less moist,	Pupils very dilated, eyes dry, lids tense, raised	Pupils very small or dilated, eyes very dry, lids very tense	Lids drooping, eyes closed or open and fixed
SKIN TONE	Variable	Rosy hue (despite skin colour) blood flow to skin	Less rosy hue, despite skin colour (blood flows to skin)	Pale hue despite skin colour (blood flow to muscles)	May be pale and/or flushed	Noticeably pale
HUMIDITY Skin	Dry	Dry	Increased sweat	Increased sweat, may be cold	Cold sweat	Cold sweat
Mouth	Variable	Moist	Less moist	Dry	Dry	Dry
HANDS & FEET (TEMPERATURE)	May be warm or cool	Warm	Cool	Cool	Extremes of cold and hot	Cold
DIGESTION	Variable	Increase	Decrease	Stops	Evacuate bowel bladder	Stopped
EMOTIONS	Grief sadness shame disgust	Calm pleasure love sexual arousal	Anger shame disgust anxiety excitement sexual climax	Rage fear	Terror, may be dissociation	May be too dissociated to feel anything
CONTACT WITH SELF AND OTHERS	Withdrawn	Probable	Possible	Limited	Not likely	Impossible
FRONTAL CORTEX	May/may not be accessible	Should be accessible	Should be accessible	May/maynot be accessible	Likely inaccessible	Inaccessible
INTEGRATION	Not likely	Likely	Likely	Not likely	Impossible	Impossible
RECOMMENDED INTERVENTION	**Activate, Gently increase energy**	**Continue Therapy Direction**	**Continue Therapy Direction**	**Put on Brakes**	**Slam on Brakes**	**Medical emergency Call Paramedics**

Observe Client states: To modulate arousal with brakes. Adjust in yourself: To think clearly & prevent vicarious trauma & compassion fatigue

Psychoeducation

When clients are given knowledge about the impact of trauma, they gain meta-cognition and can make more sense of their experiences, normalising, rather than being flooded by emotions. However pace this very carefully, without seeming the 'all knowing powerful expert'. Give information that the client can take away to digest. Eg Directed reading;Youtube videos. Areas include:

- Nature of traumatisation – the universality of trauma symptoms, the safeguarding role of dissociation – how the normal brain and body respond to a traumatic event
- The therapy process – contract, duration, goals etc
- Life skills for well-being: nutrition, sleep, rest, exercise and play/leisure activities
- The role of boundaries – being able to say no.
- The role of shame in complex trauma
- Specific problem areas such as self medication, substance abuse, and sexual functioning
- The role of empathy and compassion for self and others

Oases, Anchors and the Safe Place (Rothschild 2000)

Oases: activities that offer a break from the trauma – needs to demand concentration and attention (ie not watching TV as thought will wander) Eg gardening / repairing the car / computer games etc

Anchors: a concrete observable resource chosen from person's life that gives a feeling of relief and well being– eg a person / a favourite pet / a place / an object (a tree, boat, a stone) an activity (swimming / hiking). Establish at least one anchor to use as a braking tool anytime the therapy gets tough. Eg notice when a client finds a positive; eg when talking about a pet , their colour changes.

The Safe Place: This is a specialised anchor – a current or remembered site of projection – preferable for it to be an actual place – so as to have all senses engaged with it – sights/sounds smells etc. Some clients will not be able to find these images – or if they do it becomes contaminated – Can then work to allow it to be good enough – and also to enable to client to feel in control of it. Client may also fear feeling Ok – (issues of hypervigilance).

Dealing with Acute intrusion and Flashbacks

Grounding skills help client focus on immediate here and now – a means of engaging the cortex, rather than being stuck in the amygdala's early warning system: In the immediate situation the therapist **firmly** draws attention to the here and now and engages the client's e**xteroceptors**: 'look at me - what colour is my shirt', or 'look at the street outside –how many cars can you see' etc.

SIBAM: A model for working with Dissociation

Peter Levine (1986) developed this model to work on integrating Trauma memories. It is largely for Phase 2 but there is valuable application for Phase 1 for embedding the safe resources.
NOTE: It may not be helpful for those seriously cut off from body sensations

Sensation **I**mage **B**ehaviour **A**ffect **M**eaning

Every experience is made up of these 5 elements. Normal non traumatic events are remembered in all the elements. In trauma the elements get dissociated.
eg stuck with sensation, image and behaviour but no affect or meaning.
The goal in therapy is to enable integration of all the dissociated elements.

Sensation

Body awareness in the here and now eg temperature, heart, breathing

Behaviour

Behaviour in the here and now that can be OBSERVED as well as felt: all things muscular – skeletal muscles – bones, eye movements, body movements - changes in ANS – flushing – heart rate going up

Affect

Feelings and emotions in the here and now – eg happy, sad, anxious, scared
'Right now I'm feeling……'

Meaning

Thought processes and words in the here and now.
Babette Rothschild (unlike Levine) differentiates between 2 types of meaning:
1) Little M meanings (similar to Adlerian private Logic): analogies /own logic / decisions:
'because of this then that…'
Judgements: *'all men are…'* These keep the Trauma held in.

2) Big M meanings: 'Aha' phenomenon:
'Now I understand …now I have a different perception'
Trauma is RELEASED through new perceptions

Image

Images of S, B, A and M ***in the past.***
Eg 'when I remember the look on my Father's face I remember my heart beating and feeling scared
When using the SIBAM model 'Image' refers to aspects and elements of the past.

Use of SIBAM in Phase 1

1) **Use as a means of assessing** where client focuses memory – mainly a diagnostic tool – this helps identify where therapist can make contact with the client

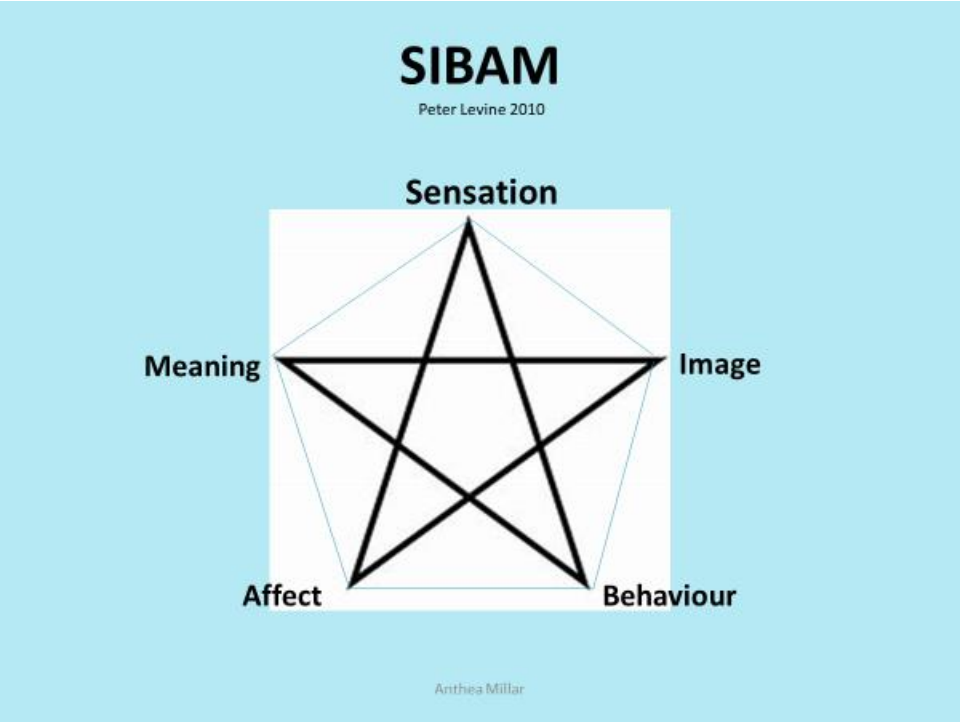
Eg if client is all 'meanings' can initially make contact through meanings.

2) **Anchors** (analogy of 'screen saver') – a good experience. SIBAM offers way to help person find an anchor. An anchor needs to be a REAL experience that integrates all elements and has as strong or stronger somatic markers as the trauma memory.

eg: 'my sister'

When you name her what happens in your body'
What affect do you associate with these sensations
Any images come to mind?
What's her voice like – can you hear it?
What does your relationship with her mean to you?
How do you feel that?
What might I say to call her up?(trigger word)

If the client chooses an experience that does not include all elements, be encouraging but look for another option. If a client can't find an anchor then they are not ready to move from phase 1. It's important for the client to be consciously aware of all the elements – not just that they are observed by the therapist.



Dual Attention: Re-Building Connections

We need to help our clients hold **dual attention and rebuild connection and integration. D**ual awareness is crucial for safe trauma therapy. It acts as a means of braking and containment.

This is a normal process for non-traumatised people who are able to hold awareness of two or more areas of experience simultaneously.
Eg: if our heart is beating fast we can link this to the fact that we have just run up the stairs, or if we have a pain in the gut we can link this to having eaten too much.

However where there is extreme fear, this splits perception – there is a loss of discrimination, leading to distorted perceptions – danger is everywhere and fear is constant. Dual attention is lost.

In therapy we need to enable the clients to create a combination of the **experiencing self** and the **observing self** (Van der Kolk). This creates a metaphorical 'bridge' between the amygdala and the cortex, enabling reduction of the fight flight responses.

When we have built up strong patterns of fear, or phobias about specific situations, it can feel impossible to face these fears. The **amygdala**, the part of the brain that is on the alert to our fears will continue to send the 'fight flight freeze' messages to our body until the cortex identifies that this is no longer necessary.

People who were 'paralysed' by fear and then develop PTSD moved into a profound trance during the traumatic event, long enough for the event to be deeply etched on the amygdala. From then on, whenever the amygdala finds a sensory match or part match, it sets off an alarm.

Therefore, to help our clients overcome long established fears, we need to support them in building a 'bridge' between the messages being sent by the amygdala and the higher functioning parts of the brain, most particularly the pre-frontal cortex.

Applying Dual Attention to Flashbacks and Nightmares

Ref: Rothschild (2000) The Body remembers– p 132

Do NOT work on resolving PTSD through flashbacks as the experience of a flashback reinforces feelings of terror and helplessness. The first step is to teach the person stop the flashbacks. When flashbacks are under control clients may be able to build sufficient resources to address the trauma memories. The client first needs to be helped find their **observing self** using grounding techniques. If a flashback happens in the therapy session the therapist needs to firmly bring back the client into the room: eg 'what colour is my hair' 'how many leaves are on that plant'? 'How many pictures are on the wall?'

A Process for Managing Flashbacks and Nightmares:

Once the client's observing self is working again, helping the client in the session to prepare the following process for when they experience a flashback or nightmare, may be helpful:
(it is important not to impose any one technique on a client, but to negotiate what might be

Right now I am ***feeling***……(insert name of current emotion (usually fear)
And I am ***sensing*** in my body…….(name at least 3 body sensations)
Because I am ***remembering***……(name the trauma by title only – NO details)
At the same time I am looking around where I am ***NOW*** in …(say actual year)
Here….(name the place where you are)
And I can see….(describe some of the things that you see right ***now*** in this ***place***
And so I know…..(name the trauma, by title only, again)
Is not happening to me any more.

This can be adapted for nightmares and used as a ritual before sleep, to prepare for the expected nightmare, as follows:

I am going to awaken in the night ***feeling***……(insert name of current emotion)
And will be ***sensing*** in my body…….(name at least 3 anticipated body sensations)
Because I will be ***remembering***……(name the trauma by title only – NO details)
At the same time I will be looking around where I am ***NOW*** in …(say actual year)
Here….(name the place where you are)
And I will see….(describe some of the things that you see right ***now*** in this ***place***
And so I will know…..(name the trauma, by title only, again)
Is not happening now / any more.

Pendulating

This simple 'pendulum' process can be used when there is a well established 'safe place' or 'anchor' that you have established can be easily accessed by the client. Details of the distressing moment need not be identified in detail – but some code name given – eg 'boat'.

1. Establish the safe place or anchor – ask the client to describe the qualities of it – the feelings experienced in the body, the thoughts and meaning around this safe place.
2. Briefly identifying the distress point and code name - what are your feelings in the body?
3. Say to the client 'move your attention to the safe place' (use specific name)
4. Move attention to the distressing place
5. Continue moving from one to the other for 6-8 'swings' of the pendulum.
6. Ensure you finish at the safe place.

This simple process can help neutralise the power of the distress, creating a 'bridge in the brain'.

Phase 2 Working with Trauma Experiences and Memories

Remembering is NOT always required for positive healing.
The goal of trauma recovery is to improve the client's quality of life on a daily basis: this does not *have* to include remembering the details of your traumas.

When the client feels completely stable THEN they can decide if they wish to:

- Tackle memories in details
- Review them in general
- Leave them alone entirely
- Table this decision until a later time

Check which phase is appropriate, by evaluating the following with the client:
I have adequate amounts of the basics needed for daily life: shelter, food, clothing, companionship.
I control my memories and symptoms – I can calm myself and stop a flashback.
I can manage a normal day (whatever is normal previously and in my culture, family and job).
Basic safety: I am not continuing to live under the threat of trauma: (here are just some examples):

- Following an accident, the cause has been repaired/replaced
- If a refugee – I have been granted legal residence in the new country
- If a victim of violence all the physical injuries are healed and legal procedures are concluded. The perpetrator is incarcerated or deceased, or you are protected by distance etc
- If a victim of domestic violence, you are no longer living with the abuser, or the abuse has stopped and you are getting counselling
- If you were abused as a child, you are no longer living with or near the abuser, or in an abusive relationship.
- Direct experience of racism and other serious oppressions are reduced.

Before moving on to processing trauma memories if things are stable then consider the following:

Does the client want to revisit the traumatic memories?

When paying attention to the past does the client lose connection with their present life?
Trauma memory needs to be a sideline NOT the main pre-occupation
Some people get worse when attending to their past. Check which category he or she is in:

Trauma resolved: 'if it ain't broke don't fix it – do not prod and probe.
Single trauma: eg RTA – no other traumas in history – could be Ok
Multiple trauma – stable – can organise and process events one at a time without confusion or intrusion of other issues
Multiple trauma – in a jumble– feel flooded by other traumas when talk about one

Benefits of processing memories:

- Identifying and changing private logic that keeps the client bound to the trauma
- Imagining alternative responses that could be useful in the future
- Actually rehearsing movements that were frozen / prevented during the event
- Being able to manage self-defence training
- Reclaiming resources that seemed lost in the trauma
- Imagining a different ending

Phase Three: Reconnection and Integration

This phase involves the creation of a new sense of self and a new future. It is less of a time-based phase, but a process that runs right through all phases of the healing process.

It involves redefining oneself in the context of positive and meaningful relationships. Through this process, the trauma no longer is a defining and organising principle is someone's life. The trauma becomes integrated into their life story but is not the only story that defines them. The person recognises its impact, but is no longer a victim, but a survivor who is now ready to take concrete steps towards empowerment and self-determined living.

Recovery is not defined by complete absence of thoughts or feelings about the traumatic experience but being able to live with it in a way that it isn't in control of the survivor's life.

Posttraumatic Growth Kfir 1989, Calhoun & Tedeschi 2004

The term ***Posttraumatic growth,*** the idea that human beings can be changed by their encounters with life challenges, sometimes in radically positive ways, is not new. The theme is present in ancient spiritual and religious traditions, literature, and philosophy. Nira Kfir in describing her Crisis Intervention model emphasises that 'real change is often started from the depths of the pit of despair' (1989 p 44).

What forms does Posttraumatic growth take? Posttraumatic growth tends to occur in five general areas which will differ from person to person:

- a sense that new opportunities have emerged from the struggle, opening up possibilities that were not present before. An opportunity to challenge destructive aspects of private logic.
- a change in relationships with others: eg experiencing closer relationships with some specific people, and an increased sense of connection to others who suffer.
- an increased sense of one's own strength – "*if I lived through that, I can face anything*".
- a greater appreciation for life in general and positive meeting of the Life tasks.
- a deepening of their spiritual lives, which can also involve a significant change in one's belief system.

Most of us, when we face very difficult losses or great suffering, will have a variety of highly distressing psychological reactions. **Just because individuals experience growth does <u>not</u> mean that they will not suffer.** Distress is typical when we face traumatic events. The concept of posttraumatic growth does not imply that traumatic events are good – they are not. But for many, life crises, and the struggles they provoke, invite new opportunities. Self-renewal occurs because we are forced to explore painful depths that we wouldn't have chosen to experience.

Depth of inner exploration creates a deeper sense of connectedness to our personal life, together with stronger bonds of connectedness to others and the universe – It is precisely the shattering effect of trauma that forces us to think in new ways feel at deeper levels and relate to others more compassionately.

Safety and Well-being of Practitioners

Ensuring the well -being of all workers in helping organisations is crucial to a trauma informed approach. For all of us in the helping professions, our very caring means also meeting the challenge of absorbing the pain from those we hope to help. Yet too often we may have little awareness of its traumatic impact.

Izzo and Carpel Miller (2010) coined the term **Second Hand Shock** and view it as encompassing the wide range of physical, emotional, cognitive and spiritual effects from the indirect experience of trauma and general work exhaustion. This includes Compassion Fatigue, Vicarious Trauma, and Secondary Traumatic Stress. I also include Burnout and Counter Transference under this umbrella term.

They use the analogy of second hand, or passive smoking. Breathing in smoky air gets into your bloodstream and the smell remains on your clothes. If there is prolonged exposure, especially if you already have some respiratory challenges, it has considerable risks to health.

Compassion Fatigue (CF) Ref: Figley (2002) Mathieu (2012)

CF refers to the profound emotional and physical exhaustion that takes place when helpers are unable to refuel and regenerate. It is the gradual erosion of the hope, empathy and compassion to others and crucially to ourselves. Everyone of us who cares about the people we work with may develop a certain amount of it – it is not about doing something wrong, but because we care.

Primary Trauma & Countertransference

For helping professionals there are two kinds of primary trauma: From our personal life (childhood, war, accidents etc) or caused by work related exposure – eg as a first responder or working in a war torn country etc Challenges arise when we have not had the opportunity to undertake our own trauma work, and/or are unaware of the ways our trauma history is impacting negatively. Without this awareness, the normal countertransference process (a displacement of the helper's experience onto the client) can become destructive. It can also make us more vulnerable to vicarious trauma when working with other traumatized people.

Secondary Trauma (ST) Ref: Stamm (2009, 2012) Mathieu (2012)

ST results from a *secondary* exposure to trauma such as a client re-telling their trauma, debriefing colleagues, reading case files, sitting in court hearing graphic testimony, watching vivid news films/documentaries. This can lead to PTSD type symptoms such as nightmares or intrusive thoughts about the traumatic event, avoidance, tension and irritability, insomnia and emotional numbing.

Vicarious Trauma (VT) Ref: Pearlman & Saakvitne (1995) Mathieu (2012)

VT describes the profound shift of our world view and a damaging alteration of our beliefs following repeated and exposure to traumatic material. The world often seen only through the lens of traumatic experience. It is a cumulative process after hearing hundreds of traumatic stories that transfer onto us and stick so we also become traumatised by the images and details. We may become increasingly numbed, or feel overwhelmed by images that replay. VT could occur following multiple ST events.

Burnout Ref: Stamm (2009, 2012) Mathieu (2012)

Burnout describes the physical and emotional exhaustion that workers in any field can experience when they have low job satisfaction and feel powerless and overwhelmed at work. Poor pay, unrealistic demands, heavy workload, poor management and supervision can all contribute. However, it does not necessarily include a traumatic element, or mean that our view of the world has been damaged, or that we have lost the ability to feel compassion for others. Unlike CF, VT and ST, burnout can be fairly easily resolved: changing jobs can provide immediate relief.

Trauma Exposure Response

Ref: Laura van Dernoot Lipsky (2009) 'Trauma Stewardship'

'Trauma Exposure Response' identifies 16 signs that are common to the transformation that takes place within us following exposure to the suffering of others, resulting in the world feeling and looking different.

Do any of these signs relate to your experiences in your work?

1. Feeling helpless and hopeless
2. A sense that one can never do enough
3. Hypervigilance
4. Diminished creativity
5. Inability to embrace complexity
6. Minimizing
7. Chronic exhaustion/physical ailments
8. Inability to listen/deliberate avoidance
9. Dissociative moments
10. Sense of persecution
11. Guilt
12. Fear
13. Anger and Cynicism
14. Inability to empathise/numbing
15. Addictions

References and Resources

Dana, D. (2018) The Polyvagal Theory in Therapy: Engaging the Rhythm of Regulation. Norton
Dana, D (2020) Polyvagal Exercises for Safety and Connection. New York: Norton
Dana, D (2020) Polyvagal Flipchart: Understanding the Science of Safety. New York: Norton
Felitti, V. J., Anda, et al. (1998). The Adverse Childhood Experiences (ACE) Study. American Journal of Preventative Medicine, 14(4), 245-258.
Fisher, J. (2017) Healing the Fragmented Selves of Trauma Survivors: Overcoming Internal Self-Alienation. Routledge.
Herman, J. (1992). Trauma and Recovery. New York: Basic Books.
Johnstone, L. (2014) A Straight Talking Guide to Psychiatric Diagnosis. PCCS Books
Levine, P. & Kline, M. (2007) Trauma through a child's eyes**.** Berkeley: North Atlantic Books
Levine, P. (2010) In an Unspoken Voice. Berkeley: North Atlantic Books
Mathieu, F. (2012) The Compassion Fatigue Workbook. New York: Routledge
Millar, A. (2013) Trauma Therapy: An Adlerian Perspective. Journal of Individual Psychology, 69-3.
Millar, A. (2017) Trauma, Connection and Recovery. In Adlerian Year Book 2017. London: ASIIP
Porges, S. (2017) The Pocket guide to the Polyvagal Theory. New York: Norton
Rothschild, B. (2000) The Body Remembers. New York: Norton & Norton.
Rothschild, B. (2017) The Body Remembers. Vol 2: Revolutionizing Trauma Treatment. Norton.
Sanderson, C. (2013) Counselling Skills for working with trauma: Healing from Child Sexual Abuse, Sexual Violence and Domestic Abuse. London: Jessica Kingsley.
Sperry, L. & Sperry, J. (2020) Case Conceptualization. 2nd Edition. New York: Routledge
Treisman, K. (2017) A Therapeutic Treasure Box for Working with Children and Adolescents with Developmental Trauma: Creative Techniques and Activities London: Jessica Kingsley.
Van der Kolk, B.A. (2014). The Body Keeps the Score. New York: Viking/Penguin Books

Web Resources

Blue Knot Foundation: www.blueknot.org.au
Excellent detailed resources (237 pages) on trauma informed practice for Complex Trauma:
Practice Guidelines for Clinical Treatment of Complex Trauma (2019)
file:///C:/Users/anthe/Documents/Trauma%20Informed%20workshop/BlueKnot_Practice_Guidelines_2019.pdf
National Sexual Violence Resource Center www.nsvrc.org
International Society for Traumatic Stress Studies http://www.istss.org/resources/index.htm
David Baldwin's Trauma Pages: http://www.trauma-pages.com/pg4.htm
Bessel Van der Kolk's web page: http://www.traumacenter.org
Babette Rothschild website: http://www.somatictraumatherapy.com
National Institute for the Clinical Application of Behavioral Medicine www.nicabm.com
Bruce Perry: Child Trauma Academy: http://childtrauma.org/
Ricky Greenwald site focusing on children and trauma http://www.childtrauma.com
International Society for the study of Trauma and Dissociation http://www.isst-d.org
SAMHSA Substance Abuse and Mental Health Services – Guidance for a Trauma Informed Approach
https://store.samhsa.gov/system/files/sma14-4884.pdf