Section 2: Trauma-Informed Care

What is "Trauma-Informed Care" (TIC)?

Trauma-informed care, or TIC, refers to a frame of reference and set of operational processes adopted in behavioral health care services. It incorporates evidence about the prevalence and impact of traumatic events across the lifespan. Although trauma-informed care can be extrapolated to trauma-informed "response" or even trauma-informed "culture," here it refers to organizations providing mental health care and care provided to those with developmental disabilities or other conditions requiring extensive support.

TIC is **a person-centered response** that focuses on improving functioning over curing mental illness (or "fixing" something "broken"). It recognizes that people are more than their labels and diagnoses. It also recognizes that relationships are a common context for traumatic events, and that healing most often occurs in the context of relationships. As a result, all contact has the potential for healing as well as for harm. Additionally, all people involved in the transactions are considered.

Trauma-Informed Care **comprehends the universality of overwhelming adverse traumatic events**. It recognizes the role of traumatic events in the development of and symptoms related to conditions catalogued in the DSM IVR. It recognizes that what is traumatic is defined by the person experiencing it, and values the subjectivity of trauma as a central function in the healing process. TIC knows how prevalent traumatic experiences are and recognizes that they impact people who provide services just as they do the people receiving the services.

Additionally, TIC **refocuses the use of evidence based and promising practices** in helping people improve their functioning, recover, and develop new skills for living. Almost all of these practices include, as central to success, **some form of learning, and practicing of healthier adaptive behaviors**. Trauma-Informed Care validates the ability of people to learn, change, and grow as central to their recovery and validates the relationship between helped and helper as a place for active and passive learning. This relationship allows for the repair and construction of more effective skills.

Attention is increasing on the **integration of physical activities** that increase calm, conscious awareness of one's physical, emotional, mental, and spiritual experience in

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What is "Trauma-Informed Care" (TIC)?, continued

the moment as well. Trauma, so often addressed with talking or whose symptoms are often addressed with drugs, is experienced in the *body*. The body talks without words, and thus interventions without words are important.

Trauma-informed care recognizes that **all behavior has meaning in context**. Past behavior is an indicator of future behavior without intervention beginning in the present. The behavior in the present is what has worked in the past to help the person survive in some way. Finding out how the behavior helps in the present gives the behavior positive meaning in context, and gets the focus off of the behavior (once safety is assured) so that finding another way to create the same meaning can occur.

Trauma-Informed Care also focuses on **the health of the person providing services** as paramount, turning the lens on managing vicarious traumatization and self-care as antidotes to burnout and the human side of compassion fatigue. More is now known about the phenomenon of "mirror neurons," firing as a mirror of the other's experience. When we engage with someone's upsetting material, even if we look fine to them, our brain is registering the trauma just as they do. It's empathic, and it has a cost to the unwary organization. Managing it is less expensive than avoiding it.

TReS and TIC focus on the **organization's business needs** as well. Organizations are accountable for meeting financial targets, engaging TReS. In care-providing situations, TIC is a tool that supports this. With a focus on engaging practices for which there is some body of evidence, and adjusting as evidence increases, shifts, or decreases as well as on focusing on strengths (which can be measured for increase) it is easier to demonstrate ROI with TIC. Organizational health is supportive of both service providers and service recipients.

Finally, while systems of response and care that are trauma-informed are always inclusive of **recovery**, recovery-based models are not necessarily trauma-informed. There are at least three valid:

1. The invaluable tradition of 12-step programs, the original source of the person-centered recovery movement, is grounded in <u>non-clinical</u> self-help, in "sufferers supporting sufferers." Including information such as the research behind TIC would be an out-of-context distraction.

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What is "Trauma-Informed Care" (TIC)?, continued

1. Adherence of meetings to the process in the 12-step model helps keeps the **common** interests of the group singly-focused. The consistency of process would be eroded by the inclusion of additional and complicating factors (the focus would be on each person instead of the meeting).

2. The relationships in the meetings, and between the sponsor and "sponsee" focus on the sharing of experiences, strength, and hope leading to spiritual growth as defined in the 12-step tradition rather than on the clinical processes of diagnosis and treatment of pathology which is still foundational in behavioral health care.

There **are** commonalities between the 12-step recovery and the ten fundamental components in mental health recovery model issued in SAMHSA's Consensus Statement on Mental Health Recovery, notably peer support, responsibility, and hope.

SAMHSA's Consensus Statement focuses on traumatic experiences as a "factor in individualized and person-centered care," again, more of the focus of behavioral health care services than of the 12-step tradition.

While Trauma-Informed Care is generally considered as part of treatment settings, it has purposeful application in educational systems, health care settings, corrections, public service systems, child-serving systems, the military and law enforcement, and in faith communities. It includes service provision of different types of care to multiple populations in multiple settings.

The TIC operating model is applicable in any situation where people relate to each other. While the profession-specific treatment skills most often associated with TIC may or may not be useful beyond the realm of behavioral health care settings.

The next portion of this section focuses on the differences between Trauma Informed Care and non-trauma informed care, as well as on connections to the Trauma-Responsive System.

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How is Trauma Informed Care different?

In a 2008 presentation to the Florida Association of Drug and Alcohol providers conference, Joan Gillece, Ph.D. (National Technical Assistance, NASMHPD) summarized and compared elements of TIC with those in non-trauma informed care as shown below:

Trauma Informed	**Non Trauma Informed**
▪ Recognition of high prevalence of trauma ▪ Recognition of primary and co-occurring trauma diagnoses ▪ Assess for traumatic histories & symptoms ▪ Recognition of culture and practices that are re-traumatizing ▪ Power/control minimized – constant attention to culture ▪ Caregivers/supporters – ***collaboration*** ▪ Address training needs of staff to improve knowledge & sensitivity ▪ Employs learning that manages the cognitive load ▪ Staff understand function of behavior (rage, repetition-compulsion, self-injury) ▪ Objective, neutral language ▪ Transparent systems open to outside parties ▪ Asking people how they prefer to be addressed ▪ Quietly making rounds and informing people of schedule ▪ “Let’s talk and find you something to do” ▪ “May I help you?”	▪ Lack of education on trauma prevalence & concept of “universal” precautions ▪ Over-diagnosis of Schizophrenia & Bipolar, Conduct D. & singular addictions ▪ Cursory or no trauma assessment ▪ “Tradition of Toughness” valued as best care approach ▪ Keys, security uniforms, staff demeanor, tone of voice ▪ Rule enforcers –***compliance*** ▪ “Patient-blaming” as *fallback* position without training ▪ Behavior seen as intentionally provocative ▪ Labeling language: manipulative, needy, “attention-seeking” ▪ Closed system – advocates discouraged ▪ Calling people by first name without permission or last name w/out title ▪ Yelling “lunch” or “medications” “If I have to tell you one more time ….” ▪ “Step away from the desk”

Where people served are consciously or unconsciously considered as somehow “less than others,” it is easier to keep traditionally-focused care in place. Traditional care is also generally easier to continue in residential environments. Why?

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How is Trauma Informed Care different?, continued

- Far more employees work on a shift-based or live-in schedule than are employed as clinicians.
- Shift-based workers are often the ones with the least amount of organizational power and lowest wages in the organization.
- The focus of their work is controlling the behavior of the people to whom they provide care to prevent harm or disturbance.
- Shift-based employees control points, levels, rewards, access, and model relationship for the people they serve in the facility. Because each person implements rules just a little differently, the systems of control they enforce are subjective and punishment/reward are often doled out unevenly.
- Organizational resources are often invested in the continuing education and development of clinical staff, who have the shortest amount of time with those served.
- Among all staff (and those whom they serve), the challenge of dealing with one's own power and authority issues is ever-present. Work on these issues most often occurs in relationships where there is a power differential and both parties are affected by each others' efforts.

In residential 24-hour care environments, the social order of power places the people with the least power together for the greatest periods of time. TIC recognizes this and emphasizes the development of the people with the least power and the greatest contact.

People who are often judged "less than" often receive care that may overlook or be unaware of the issue of the trauma of being as one is. Those labeled "developmentally disabled," "autistic," "mentally ill," "unstable" and treated as if they are defective, invisible, perhaps incurably stupid or not quite deserving of the same things as those not so labeled. People with speech and language difficulties, or who have very limited vocabularies, are often assumed to be of lesser intelligence, which may or may not be the case at all.

In some few situations providers overtly or subtly support clients or service recipients in maintaining the behaviors that allow them to be treated as "less than."

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How is Trauma Informed Care different?, continued

These moments—where power over is expressed by maintaining a population as "less than" may be because of the current comfort levels with the organizational and social culture "as is," the emotional reward of feeling "better than" others, the need to be needed, or using judgment to create a sense of safety ("we're not like them") among other reasons. In some cases, it may simply be the relationship between census and revenue. No matter what the reason, the situation simply "is."

Stigma and TIC

The representation of the TIC model presents a respectful, accepting person who focuses on collaboration over compliance. This is contrary to practices that reinforce stigma. Erving Goffman, the sociologist known for his work on frame analysis and the books "Asylum: Essays on the Social Situation of Mental Patients and Other Inmates" and "Stigma: Notes on the Management of Spoiled Identity" makes the serious issue of stigma elegantly easy to understand.

A summary of Goffman's position is this: When we judge others defective because of differences in origin, character or physiology, we cannot want for them what we want for ourselves.

This allows "us" to keep a psychological distance from "them." It allows "us" to lower our expectations, as well as to erode boundaries associated with respect, dignity, connection, and compassion towards "them." It makes it easier to view people as their diagnoses and labels, in this case, to confuse who a person is with how they behave.

Goffman's work on stigma frames TIC as a model that asks **everyone** to recognize the impact of trauma in their lives and their relationships, and that quietly invites everyone to at least temporarily recognize that the difference is in degrees—while **everyone** is affected by trauma, **trauma** affects every one **differently**. This helps reduce the risk of double-standards of behavior for service providers and service recipients and can help reduce the risk of stereotypical generalizations.

The concept of "universal exposure" expands the circle of those with spoiled identities **to include** the receptionist who battles anxiety, the clinician whose vicarious trauma separates them from their joy and family, the supervisor recovering from addiction, and anyone else in the continuum of care.

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The Person-Centered Response in Trauma-Informed Care

Processes that listen to and incorporate "the voice of the customer [client, or service recipient]"* as defined by the client are the ones with the highest levels of success. They incorporate the belief that people invest more strongly in what they help create and in a more collaborative exchange. They validate the other person: their experience, strengths, fears, and needs.

Over time, and as the influence of language became more popularly understood, "person-first" came to represent language reflecting the person as primary and any characteristics they exhibited or labels assigned through diagnosis as secondary.

This evolution in language, while an effort to reduce stigma and to focus on who the person **is**, also called attention to secondary identity characteristics. The challenge is that this also increases the focus on these (while a person with depression" may be preferable to "she's depressed" they are still different from "a person").

Efforts to categorize people based on setting forged another path from "mental health patients" to "mental health consumers" or "residents." Socially, "patient" typically refers to someone with an biologically based illness, in line with the model of mental health issues as brain disorders. "Residents" has connotations of "people who live somewhere."

The change to the use of the word "consumers" to refer to people who receive services from a behavioral health care provider adds another level of code, given the fact that a person who purchases a cup of coffee is **also** a consumer. Yet, at the counter, the person buying coffee is unlikely to label themselves a "consumer."

Even though there is no universal language that works for everyone, a person-centered response recognizes this phenomenon and the challenges it presents.

The goal is to do whatever is necessary to focus away from labels (such as diagnoses) that add to the labor required of an individual to increase levels of positive health. Person-centered responses recognize language as a tool used to keep people we deem different at bay, or somehow separate. In many cases, the actual distinction is not nearly so great, and the language is a form of psychological safety net for one group and potentially oppressive for another.

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The Person-Centered Response in Trauma-Informed Care, continued

The person-centered TIC response does not require this barrier because it recognizes the universality of adverse experiences as mediated by age at occurrence, resources, access, and many other factors. The only alternate language added to the mix, and often preferred as a way to keep the focus on everyone's vulnerability to the impact of trauma, is "the person receiving services."

The person-centered TIC response positions each person as an authority in their own world, and engages clients/consumers/current and former service recipients in the service of helping the organization incorporate their much needed voice. From the physical environment to programs and processes, input from all stakeholders is sought.

***Historical note**: *While "person-centered" or "person-first" is a term associated with communities serving those with behavioral health, physical or developmental ability concerns, the terms has its origins in "customer-centric business processes." Prior to listening to "the voice of the customer" businesses delivered what they felt were in the customer/consumer's best interests without asking the customers, and, generally speaking, those product/service definitions .*

The Universality of Adverse (Traumatic) Experiences

Although this has been alluded to in Section 1, it bears exploration in the context of Trauma-Informed Care. Since the mid-1980's, information about the prevalence and impact of overwhelming, adverse events has increased exponentially. Journalists, social scientists, physical/mental health and allied professionals and academics all began to find ways to more and more accurately count:

- violence against women, children, the elderly
- exposure to combat, terrorism, occupation or war
- impact of the work on first response professionals including EMT, LEA, police and Fire
- residency issues including forced relocation, status, and security
- the frequency and impact injury or illness, prognosis, treatment and outcome
- layoffs, strikes, workplace violence, and chronic underemployment

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The Universality of Adverse (Traumatic) Experiences, continued

- natural disasters and their aftermath
- exposure to crimes

and other overwhelming events.

The Adverse Childhood Experiences (ACE) study assessed associations between childhood maltreatment and later-life health and well-being across 17,000 people. The study was a collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic in San Diego.

A summary of the findings relative to frequency is that "almost two-thirds of [the] study participants reported at least one ACE and more than one in five reported three or more ACE" (http://www.cdc.gov/ace/findings.htm). Most profoundly, as the number of ACE increase, the risk for major health problems increases in a strong and graded fashion. These problems include alcoholism and alcohol abuse, chronic obstructive pulmonary disease (COPD), Ischemic heart disease (IHD) depression, fetal death, illicit drug use, early initiation of sexual activity, smoking, and others.

Combining a screening tool such as the ACEs survey with a more extensive catalogue of traumatic experiences may generate even more dramatic levels of exposure. Fallot and Harris, in their 2006 Trauma-Informed Services: A Self-Assessment and Planning Protocol state that "national community-based surveys find that between55 and 90% of us have experienced at least one traumatic event."

The experience of trauma, the experience of diagnosis and recovery, and the experience of relating to others who have experienced trauma **saturates** media, social process, and care-giving relationships.

Awareness of impact

Being aware of the impact of traumatic experiences is important in making the shift. The spectrum spans the potential for long term positive growth, the negative outcomes from short term post-traumatic stress to the development of PTSD and physical health. A trauma-informed response in terms of care and contact with others has the potential to mitigate the damaging impact, foster a return to health, and to reduce the time, trauma, and costs of healing for everyone involved.

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Awareness of impact, continued

"Post-traumatic growth" refers to both the positive psychological growth that can result from resolving life's challenges and to a deeper or more profound level of growth than probably would have been attained without the traumatic. TIC, as a strength-based offering. focuses on an individual's strengths and the development of resilience which encompasses post-traumatic groth.

Both post-traumatic growth and Trauma-Informed Care are oriented towards the improving of mental health rather than the curing of mental illness and both represent attainable goals—they are processes rather than outcomes. Post-traumatic growth is supported by the learning and practice of additional relational skills. This is an often overlooked positive outcome of the process of recovery from traumatic experiences.

"Post-traumatic stress" and "PTSD." These and other phrases describing the impact of trauma are common in a world with multiple regional conflicts and ongoing catastrophic stresses. Military and their families certainly experience traumatic events. And, they share **common yet individual** consequences of these with people victimized by crime, natural disaster, accident, terrorism or any other event that overwhelms their personal resources for soothing and re-regulation.

Traumatic events (single time or enduring experience), so very common, can have profoundly painful consequences in many areas of an individual's life. These consequences are compounded by factors such as age, developmental level, access, and resources for recovery. Whether anecdotal labeling or formal diagnosis, evidence of a person's functioning in the moment and over time after trauma is useful. (Post) traumatic stress is certainly normal following an event that causes a person to fear for their sanity, bodily integrity and physical safety.

Whether or not it resolves, lingers, or transforms into PTSD, the need for a trauma-informed response, and for trauma-informed care, is critical. It is also important to comprehend the role traumatic experiences play in the development of other disorders.

Critically important is avoiding over-generalization that inclines individuals to assume that a person to whom terrible things have happened has PTSD. They may not.

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Awareness of impact, continued

Increased long-term health risk. The ACEs Study (http://www.cdc.gov/ace/index.htm), "findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States."

The illnesses are often lifestyle related, associated with risky behaviors such as multiple sexual partners, smoking, alcohol and drug usage, which have correlation with experiences of trauma (including ACE). Consider Vincent Felitti, M.D.'s "Turning Gold Into Lead" (xnet.kp.org/permanentejournal/winter02/goldtolead.pdf), which is based on the ACE data.

About Evidence-Based Practices

Evidence-Based Practices may already be in use or being adopted by your organization. As part of offering the most effective care, they are very useful. Why might organizations not implement "evidence based practices"? Some have questions about the quality of the evidence, clinicians sometimes feel their skill and intelligence are insulted when presented as "recipe" or "cookbook" or "manualized," and other organizations simply point to the history of one's successes pointing to good practice as is.

Questions about quality of evidence are difficult to answer. By the time a practice is deemed "evidence-based" a good deal of research has established a pattern. Was the study good? Are the results replicable? How robust is the evidence?

All of these are important questions and beyond the scope of answer here. The organization's employees want the best and most effective medical treatments they can find, why wouldn't the people served by the organization and the best and most-effective medical treatment they can get too? Is "best and effective" the same thing as "evidence-based'? How robust does the evidence have to be? Thinking up the questions and considering them is more important in some ways than the actual answer.

Many times "evidence-based practices" are "manualized." "Manualized" refers to "converted to a manual," or "constructed according to a fixed, set recipe," "done using one's hand" or made more mechanistic (less automatic). The implications a person brings to their understanding of a word are racial, cultural, professional, intellectual, and above all, emotional.

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About Evidence-Based Practices, continued

Even professionally identified writers (those professionals degreed in technical writing, instructional design, and publication design) of manuals are less than happy with the term. Each of professions creates work that accounts for the concrete (such as steps, processes, key markers of fidelity, and evidence) as well as the abstract (variations, considerations, additional influences and adapting to them) while writing to their specific audience in terms of grade level, language requirements, and situation-specific design criteria.

The term "manualized" makes the practice less desirable to both parties.

Providers have spent long years of study and practicing developing their skills (both art and craft) as providers. To imply that that this "manualized practice" is better than their years of experience is an insult.

Receivers may also find this term demeaning as it implies "practice done by the hand" or because it feels awkward and forced. It is also an inaccurate reference. The problem here is that the people who have ownership in the use of manuals do stake a claim on being evidenced based.

Evidence-based practices have certain hallmarks for fidelity and self-correction, and are "guided by a manual" that should describe those and give a structure for achieving them. The nuances should be addressed by the clinician based on their training and expertise.

As "frameworks" the value of the provider's professional training is invoked, and their choices are guided rather than limited. It does call on providers to differentiate between the feelings associated with change and the change itself. It also requires being vigilant for developing an attachment to one's personal recipe for the process of recovery and healing.

For the service recipient (part of whose issue may come partly from the imposition of another's will over them) a stronger alliance is required to avoid the double bind of what may seem like a more "formulaic" approach, even with the therapeutic relationship is still the foundation of the promise of greater improvement, even if an additional highly focused intervention is added to it.

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The Transformation to Trauma-Responsive Systems (TReSIA) Organizational Attributes

Like any organizational change, TReSIA involves both the organizational function (IT, Finance, HR, different roles in the organization) and the professional function (clinical behavioral health care, in this case). With this transformation, change may occur anywhere from the level of policies and procedures to marketing –as well as service delivery.

Recognize that these attributes need to be present and visible in the process of the transformation to a trauma-responsive system:

- **Multidisciplinary teams.** Many functions and disciplines in your organization may be involved in Trauma-Informed Care, including IT, HR, Finance, Operations, the Clinical function and people served by the organization.
- **Organizational Change Management** is a practice that helps companies execute organizational changes more smoothly and effectively. Creating and following a change management plan is likely to increase speed, ease of adoption and practice of Trauma-Informed Care (TIC) by all departments, especially as Leadership considers different areas in the organization.
- **Systems change**. The lens through which work is done changes—and this impacts organizational resources (people and places), processes (the steps in getting work done), and systems (the interfacing elements in and among agencies) the continuum of service. Even though actions and focal points are prioritized, the goal of the transformation is to change systems and communities.
- **Recognition of the universality of adverse/traumatic experiences.** TReSIA recognizes that without exception, people experience events that overwhelm them, render them unable to process in the moment, are difficult to integrate, and that defy meaning-making—and that what a person perceives of as traumatic is subjective. .
- **People, processes, and systems involvement.** TRESIA involves change at all three levels, with a lower risk of change in technologies. People's resistance to change may be more deeply rooted because of valued positions that support maintenance of self-protective power structures and distance from people receiving services.

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The Transformation to Trauma-Responsive Systems (TReSIA) Organizational Attributes, continued

- **Broader customer-supplier chain.** The transactions on which TRESIA focus include everyone who provides something to someone else (a supplier) and everyone who receives something from someone else (a customer). This span includes job roles, functions, interfacing agencies, customers, families, friends, and shared boards. This has two effects:
    - **First**, while "customer" is a universal term for anyone anywhere who receives something from someone else (inclusive of front desk receiving something from the business office, a clinician receiving a file from medical records, or a person receiving therapy or counseling from a clinician), we recognize that some organizations will be more comfortable calling people who receive services "consumers." Just be sure every process they touch is considered. From whom do they receive something and to whom do they provide something?
    - **Second**, expanding the customer-supplier chain reduces artificial barriers between people who provide services and people who receive them, which changes the relationship. Providers (for example, drivers, front desk people, schedulers, aides, clinicians) are in different relationship to the concept of "trauma"—from the Risking Connection perspective, the change in frame humanizes everyone involved and makes everyone's work a little easier.
- **Integration of the known impact of adverse/traumatic experiences**. Given the universality of trauma, and growing acknowledgement of the impact of exposure to others' experiences, as the transformation progresses, leadership and administration may choose to adjust operational practices and processes. For example, potential changes are considered in light of multiple criteria with questions such as these (additional questions are found in Section 3 in the assessment):
    - Are there HR policies or treatment policies that have a punitive or coercive tone to them? How do we know?
    - Are any of the systems of recognition and reward based on economies (tokens, lights, stars, points, levels) rather than relationship? How does this model the world in which we hope for people to live?

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The Transformation to Trauma-Responsive Systems (TReSIA) Organizational Attributes, continued

- How might morale, performance, and benefits usage levels be related to the impact of ongoing exposure to others' trauma and one's own? How might that be impacted?
- How might the prevalence of traumatic experiences impact those providing care? When caregivers have (as most do) histories of trauma, either primary or secondary, what is the impact of contact on them?

- **Shifts in frame of reference.** The lens through which services are provided shifts (consciously as well as unconsciously) to a strengths-based, relational, collaborative process, characteristics of the TIC foundation for recovery and resilience. This may also impact processes such as:
  - **Initial assessment** (which may add universal screening for trauma and adverse experiences **as well as** assess strengths and resilience). A question to consider here is "How to perform a universal screening for trauma without re-traumatizing or expecting major disclosure without having developed trust?"
  - **Planning for health and recovery** (which now engage service recipients more directly). Improving existing mental health instead of managing mental illness is a different frame. Questions such as "What tools to use to engage clients/service recipients in self-directed planning and action? What about electronic access and completion? And, how to accommodate different levels of users?" should be considered.
  - **Records**—as electronic health records are implemented, including person-centered planning with the person's input will change records. Obviously, the idea of implementing electronic healthcare records (EHRs) invokes a huge set of questions. And, if EHRs are already in use, the task of integrating consumer/client/service recipient input in goals and process is a matter of configuration and programming. Ensuring some method of integration that documents the service recipient's efforts and that demonstrates some assessment of strengths is important.

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The Transformation to Trauma-Responsive Systems (TReSIA) Organizational Attributes, continued

- **The Impact of power differentials**. The TReSIA fundamentally engages issues related to positional and assigned authority levels and stigma. Relationship, the foundation of healing and critical for recovery, takes priority over positional and assigned authority levels in TReSIA.

  Going from "power over" to "power with" in relationships is a change in boundaries for all involved. It also requires change on the part of the people served. The adjustment of power differentials can be rife with challenge.

  Processes may be resistant to change for a variety of reasons. For people who have relied authority grounded in positional respect (e.g, able to grant privileges, power over access to resources, labeling and diagnostic power,) is may be unsettling if not frightening. Sometimes, members of the group in power (insiders, or people for whom work relationships are based in authority over others) may be unable to consider policies and processes as punitive, illogical, and inappropriate.

  Systems—groups that interface in the continuum of care—are at the effect of competing for resources, perceptions of scarcity and the conundrum that having people who receive services is often a foundation for funding. There is an inevitable double bind between the mandate to helping people no longer need services and the connection of census counts to income.

Applications for TReSIA

The behavioral health field knows that increased secure attachment makes it easier for people to tolerate and even grow in the face of traumatic experiences of all sorts. While it may be difficult to develop in adult life, increasing this supports improved functioning.

This positive connection that can be remembered and called on serves as a prophylactic, creating a buffer for difficult times. This idea, central to TIC, has relevance anywhere people gather and engage each other. This includes all organizational settings, which makes it relevant in TReSIA.

So does the remedy of increasing one's ability to manage and modulate emotions. In every workplace, social group, faith community and family, there are people who either have difficulty feeling their feelings without becoming extreme, or who run the other way from essential parts of life like conflict, feedback, change and growth—all of which carry the risk of encountering "big feelings." Another of the key personal skills in TIC is the ability to manage and modulate feelings.

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Applications for TReSIA, continued

While the **clinical** processes associated with TIC add layers of specific psychoeducational and deliberately therapeutic process, Trauma-Informed Care in its most basic form is really about a "trauma informed culture." Once again, this expands the realm to Trauma-Responsive Systems. It is evident in organizational leadership, in the Human Resources cycle of hiring to release, in increasing the quality of contact in care settings and communities, in the provision of care in physical medicine, and, among other things, increased access to learning capacity.

Imagine what would happen if international relations comprehended the impact of traumatized cultures as they considered their actions. For example, colonialism as an overlay on tribal cultures leaves the culture disconnected from its inherent values. This fundamental disrespect breeds contempt for the colonizer and for cultures similar to it, and others whose cultures are similar to the colonizer may apply inappropriate cultural expectations to the traumatized culture.

When framed through the lens described by Gillece (2008) and supported by TIC models such as Sidran Institute's Risking Connection® relating in all of life from a trauma-informed perspective is valuable. The increase of respect, civility, connection and empathy—and certainly hope—supports a healthier future.

Imagine interactions if people responded to each other through a trauma-informed lens. Thus, "Trauma-Informed Care" can generalize to "Trauma-Informed Response" and even "Trauma-Informed Culture." Wherever you, your staff, and your organization is on the continuum, the third part of this document can help you foster even more results for the effort you invest.

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