Introduction

The goal of the Trauma Informed Care Initiative of the Tennessee Coalition to End Domestic and Sexual Violence is to promote trauma informed care in domestic and sexual violence programs. Established in 1983, the Tennessee Coalition to End Domestic and Sexual Violence is a statewide non-profit coalition of diverse community leaders and program members committed to our mission of ending domestic and sexual violence in the lives of Tennesseans and changing societal attitudes and institutions which promote and condone violence through public policy advocacy, education, and activities which increase the capacity of programs and communities to address such violence. The Coalition provides a wide variety of training and technical assistance on domestic and sexual violence to communities throughout Tennessee, including an annual conference. It is the policy of the Coalition to support and encourage Tennessee domestic and sexual violence programs to be trauma informed to better serve survivors.

Victims of domestic and sexual violence are survivors of traumatic experiences, and recognizing and addressing that trauma is crucial in serving survivors and aiding in their recovery. It is critical that advocates working in domestic and sexual violence programs possess basic understanding of how traumatic experiences impact the survivors they serve. It is important for advocates to understand trauma, trauma reactions, and how these reactions affect their interactions with survivors. This policy will provide best practices for domestic violence and sexual assault programs working with trauma survivors.

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What is Trauma?

A trauma is an incident or event that is, or is perceived to be, threatening to one's own life or bodily integrity. Trauma is a subjective experience of terror and helplessness. Some examples of traumatic experiences are combat, sexual or physical abuse, terrorism, or serious accidents. A hallmark of traumatic experience is that it typically overwhelms an individual mentally, emotionally, and physically.

According to Dr. Judith Lewis Herman, in her book *Trauma and Recovery*, psychological trauma is characterized by feelings of:

- intense fear;
- helplessness;
- loss of control; and
- threat of annihilation.

Advocates know that survivors of domestic and sexual violence experience the feelings that characterize trauma even if they haven't named it trauma. It is important that advocates understand that no two survivors will respond to the traumatic experience of domestic and sexual violence in the exact same way. Traumatic reactions are subjective and are not a sign of emotional or psychological weakness, but are typical reactions to the traumatic experience of domestic and sexual violence.

Impact of Trauma on the Body: Physical and Emotional Reactions[1]

After a trauma, people may go through a wide range of normal responses. Such reactions may be experienced not only by people who experienced the trauma first-hand, but by those who have witnessed or heard about the trauma, or been involved

[1] Used with permission from Dr. Patti Levine.

with those immediately affected. Many reactions can be triggered by persons, places, or things associated with the trauma. Some reactions may appear totally unrelated.

Here is a list of common physical and emotional reactions to trauma, as well as a list of helpful coping strategies. These are NORMAL reactions to ABNORMAL events.

Physical Reactions

- aches and pains like headaches, backaches, stomach aches
- sudden sweating and/or heart palpitations (fluttering)
- changes in sleep patterns, appetite, interest in sex
- constipation or diarrhea
- easily startled by noises or unexpected touch
- more susceptible to colds and illnesses
- increased use of alcohol or drugs and/or overeating

Emotional Reactions

- shock and disbelief
- fear and/or anxiety
- grief, disorientation, denial
- hyper-alertness or hypervigilance
- irritability, restlessness, outbursts of anger or rage
- emotional swings -- like crying and then laughing
- worrying or ruminating -- intrusive thoughts of the trauma
- nightmares
- flashbacks -- feeling like the trauma is happening now
- feelings of helplessness, panic, feeling out of control
- increased need to control everyday experiences
- minimizing the experience
- attempts to avoid anything associated with trauma
- tendency to isolate oneself
- feelings of detachment
- concern over burdening others with problems
- emotional numbing or restricted range of feelings
- difficulty trusting and/or feelings of betrayal
- difficulty concentrating or remembering
- feelings of self-blame and/or survivor guilt
- shame
- diminished interest in everyday activities or depression
- unpleasant past memories resurfacing
- loss of a sense of order or fairness in the world; expectation of doom and fear of the future

Sexual assault is a leading cause of trauma for women. According to the World Health Organization, compared to adults who have never been sexually assaulted, an adult survivor is:

- 3 times as likely to have major depression.
- 4 times as likely to contemplate suicide.
- 6 times more likely to suffer from post-traumatic stress disorder.
- 13 times as likely to attempt suicide (13% of sexual assault victims attempt suicide).
- 26 times more likely to abuse drugs and alcohol.

Impact of Trauma on the Brain[2]: Fight, Flight, and Freeze

There are three main divisions of the brain: the brain stem, the limbic system, and the cerebral cortex. The part of the brain most impacted by trauma is the limbic system which includes the amygdala and the hippocampus. The limbic system is the center of survival functions and it responds to trauma by releasing hormones that tell the body to prepare for defensive action.

The amygdala signals an alarm to the hypothalamus, which releases a chain of actions that result in the release of the hormones epinephrine and norepinephrine to mobilize the body for fight or flight (increase respiration and heart rate, more oxygen, sending blood away from the skin and into the large muscles for quick movement). Once the trauma is over, or fight or flight has been successful, another series of actions releases cortisol which will halt the alarm reaction and the production of epinephrine and norepinephrine, helping to restore the body to homeostasis or equilibrium.

When death feels imminent, escape is impossible, or the traumatic threat is prolonged, the limbic system can cause a state of freezing called tonic immobility (deer in the headlights).

Fight, flight, and freeze are automatic survival reactions, but they are much more complex than simple reflexes. If the perception of the limbic system is that there is adequate strength, time, and space for flight, then the body breaks into a run. If the limbic system perceives no time to flee, but enough strength to defend, then the body will fight. If the limbic system perceives there is neither time nor strength for flight or fight, then the body will freeze. In a freeze state, the victim enters an altered reality. Time slows, and there is little or no fear or pain.

It is very important to understand that the limbic/autonomic nervous system responses are instantaneous, instinctive responses to a perceived threat, not chosen by thoughtful consideration.

[2] Adapted from *The Body Remembers* by Babette Rothschild and a speech by Bessel van der Kolk.

Many trauma survivors feel much guilt or shame for freezing or "going dead" and not doing more to protect themselves or others by fighting back or running away.

In Post Traumatic Stress Disorder, the system has broken down. Researchers speculate that the release of too little cortisol may result in a state of permanent arousal or hyperarousal. Cortisol may also be implicated in the development of dissociation (the freeze state mentioned above) that can persist or reoccur when the trauma is over.

> ***To accept national amnesia would be bad for another …reason. It would be in effect to victimize the victims of apartheid a second time around. We would have denied something that contributed to the identity of who they were.***
> ***--Archbishop Desmond Tutu***

Impact of Trauma on the Brain: Trauma and Memory

Within the limbic system there are two related areas central to memory processing and storage: the hippocampus and the amygdala. These areas are centrally involved in recording, filing, and remembering traumatic events.

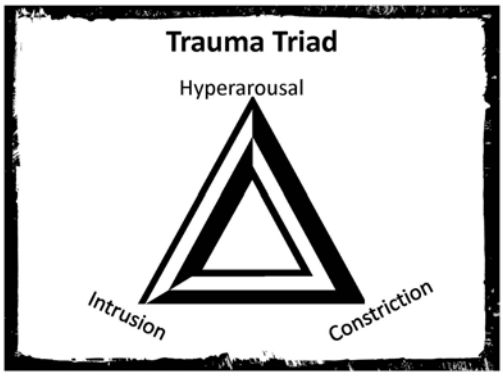
The amygdala aids in the processing of highly charged emotional memories (such as terror) and bodily sensations. The hippocampus gives time and space context to an event, putting our memories into their proper perspective and place in our life's timeline. Hippocampal processing gives events a beginning, a middle, and an end.

The activity of the hippocampus is often suppressed during trauma (the release of cortisol may suppress the hippocampus), and the event is prevented from occupying its proper position in the person's history. Instead, it continues to invade the present in the form of flashbacks, dreams, and body memories (this is known as intrusion).

Another area of the brain that is suppressed during trauma is Broca's area, the speech center. This reality is reflected in the term "speechless terror." What memory there is will be in the form of jumbled images and sensations, rather than in a linear narrative (because the amygdala is not affected by cortisol or suppressed during trauma).

Those who suffer from Post Traumatic Stress Disorder may become fearful, not only of the trauma itself, but also of their own bodily reactions to trauma. Body signals that once provided essential information can become danger signals. Increased heart rate (even from excitement or pleasure), certain body positions, or orientations in space can trigger a fear response. The ability to orient to safety and danger is compromised when many things, or sometimes all things, are perceived as dangerous.

Impact of Trauma on the Brain: Lasting Effects



The impact of trauma can be long lasting and can vacillate between hyperarousal, intrusion, and constriction

Hyperarousal is a state of permanent alert, during which the person may startle easily, react irritably to small provocations, or sleep poorly. The physiological changes associated with hyperarousal are both extensive and enduring, and brain chemistry is severely impacted.

Intrusion occurs when the past traumatic event continues to invade the present in the form of flashbacks, dreams, and body memories. These memories are not linear or verbal. Survivors report that there is a frozen wordless quality to the memories: vivid sensations, images, fragmentary sensation, and images without context. **Intrusion o**verwhelms ordinary capacity to bear feelings. Often, survivors will do anything to avoid experiencing these memories, which leads to constriction.

Survivors experience **Constriction** at the time of the traumatic event in the form of:
- Numbed or distorted perceptions;
- Out of body feeling;
- Altered sense of time, slow motion

Constriction also occurs after the event and may become a habitual coping mechanism, leading to dissociation, alcohol, or drugs, and a narrowing of one's life and activities.

After trauma, an individual alternates between hyperarousal, intrusion, and constriction. At first, hyperarousal and intrusion predominate. Over time, constriction predominates.

Things to Remember
- The brain has an automatic response to trauma.
- Trauma memory is not stored in linear form.
- The impact of trauma can be long lasting and can vacillate between hyperarousal, intrusion, and constriction.

Impact of Trauma on Interaction and Engagement:
Information Sheet for Domestic Violence Advocates

Trauma can affect a survivor's…

- Interactions.
- Stress tolerance and ability to regulate emotions.
- Responses to negative feedback.
- Ability to screen out distractions.

It could look like…

- A survivor seeming "cool" and detached.
- A survivor who is highly sensitive and whose feelings are easily hurt.
- A survivor is suspicious and not trusting.
- A survivor does not "read" or trust warmth and caring from staff and other survivors.

When someone is experiencing a trauma response, she/he may…

- Be able to talk to you about what is happening.
- Have trouble with the narrative of her/his story.
- Not notice what is happening.
- Not know what will help or think that nothing will.
- Need some time alone or be comforted by having you near.
- Feel too upset or overwhelmed to interact with you.
- Not want to say what she needs because she does not feel safe enough, she may want to protect you, or she may believe that she should not say

What is Trauma Informed Care?

Trauma-informed care views service provision through a lens of trauma. It involves having a basic understanding of trauma and how trauma impacts survivors and designing services to acknowledge the impact of violence and trauma on survivor's lives and give survivors tools to address symptoms and heal from trauma. A trauma-informed approach is sensitive and respectful: advocates seek to respond to traumatized individuals with supportive intent and consciously avoid re-traumatization.

The Center for Mental Health Services National Center for Trauma-Informed Care (NCTIC) emphasizes that a trauma-informed approach is based on the recognition that many behaviors and responses expressed by survivors are directly related to traumatic experiences. Often behaviors such as hyperarousal, constriction, and other responses to trauma are viewed as symptoms of a mental health condition, when in fact these are normal responses to traumatic experiences.

Characteristics of Trauma Informed Services
Trauma-informed services are not specific types of services, but share a set of principles that place trauma at the center of the understanding of survivors.

Trauma-informed services are:

- Focused on understanding the whole individual and context of his or her life experience.
- Infused with knowledge about the roles that violence and victimization play in the lives of survivors.
- Designed to minimize the possibilities of victimization and re-victimization.
- Hospitable and engaging for survivors.
- Designed to facilitate recovery, growth, resilience, and healing.
- Respectful of a survivor's choices and control over her recovery.
- Based on partnership with the survivor, recognizing and minimizing the power imbalance between advocate and survivor.
- Intended to emphasize survivor's strengths.
- Focused on trust and safety.
- Collaborations with non-traditional and expanded community supports (such as faith communities, friends and families, etc.)
- Culturally competent and sensitive.

Trauma informed services guide us, when trying to understand a person's behavior, to ask, "Is this related to violence and abuse?"

GENERAL PRINCIPLES WHEN WORKING WITH TRAUMA SURVIVORS
While traumatic responses are normal, expected reactions to trauma, they are also very uncomfortable for the survivor. Letting the survivor know that these responses are NORMAL can help relieve some of the distress caused by these symptoms. When a survivor learns tools to address symptoms related to trauma, she becomes empowered to better understand and manage her symptoms, which hopefully results in her feeling safer, calmer, and more capable to face additional challenges she might encounter.

What to Expect:
Letting the survivor know what to expect after experiencing a trauma can help alleviate symptoms and help her to prepare to cope with them.

- Survivors of a traumatic event may alternate between periods of intense anxiety or re-experiencing the event and periods of depression and withdrawal. That is how our brain copes with trauma.
- Some situations may "trigger" the survivor to remember the trauma vividly.
- Anniversaries of traumatic events may cause post-trauma symptoms to recur or worsen.
- Events that are related to the trauma (court dates, counseling sessions, medical appointments) can cause these symptoms to worsen temporarily.

- Survivors may become impatient with the recovery process. It takes time to heal from trauma.
- There is a new "normal" after recovering from trauma. It is not the same as the "normal" experienced before the trauma but can be rich and fulfilling in its own right.
- The survivor is telling the truth as she/he knows it.
- The survivor is a capable person with strength, wisdom, and courage.

Connection and Reflection Skills:
We know that any survivor may have difficulty engaging with an advocate who offers to help her. It is important to develop communication skills that acknowledge a person's trauma-related barriers to communication, while also following the survivor's lead in the conversation. We can do this by using two sets of skills—our connection skills and our reflection skills. Our connection skills include our ability to engage, be available, be present, convey empathy, avoid judgment, and be open and honest about what we are offering. We sometimes think of these as "lifelines," meaning that they may not be picked up immediately but are available when the other person is ready. Our reflection skills include our self-awareness and responsibility for understanding our own needs and reactions, both of which help to sustain our connection skills.

Helpful Coping Strategies for Survivors and Advocates[3]:

- mobilize a support system and reach out and connect with others, especially those who may have shared the stressful event
- talk about the traumatic experience with empathic listeners
- cry
- hard exercise like jogging, aerobics, bicycling, walking
- relaxation exercise like yoga, stretching, massage
- humor
- prayer and/or meditation; listening to relaxing guided imagery; progressive deep muscle relaxation
- hot baths
- music and art
- maintain balanced diet and sleep cycle as much as possible
- avoid over-using stimulants like caffeine, sugar, or nicotine
- commitment to something personally meaningful and important every day
- hug those you love, pets included
- proactive responses toward personal and community safety: organize or do something socially active
- write about your experience in detail, just for yourself or to share with others

[3] Used with permission from Dr. Patti Levine.

Many people find that individual, group, or family counseling is helpful. People who fully engage in recovery from trauma discover unexpected benefits. As they gradually heal their wounds, survivors find that they are also developing inner strength, compassion for others, increasing self-awareness, and often the most surprising -- a greater ability to experience joy and serenity than ever before.

Resolving the Trauma

The resolution is never complete, it is often sufficient for the survivor to turn her attention from the task of recovery to the tasks of ordinary life. Dr. Mary Harvey, a colleague of Judith Herman, set forth the following criteria for the resolution of trauma:

1. Symptoms are brought within manageable limits.
2. Survivor is able to bear the feelings associated with traumatic memories.
3. Survivor has authority over the memories.
4. Memory is a coherent narrative.
5. Self esteem has been restored.
6. Important relationships have been reestablished.
7. There has been a reconstruction of a coherent system of meaning and belief that encompasses the story of the trauma.

Suggested Best Practices - "Tell me your story…" "I want to hear your story…"

1. A commitment to non-violence and equality is essential in a domestic and sexual violence service agency. When advocate-survivor relationships are based on equality, an advocate will not use punitive interventions because they emphasize power differentials.
2. Each individual seeking services has her own unique history, background, and experience of victimization. Treat each survivor as an individual.
3. Healing and recovery is personal and individual in nature. Each survivor will react differently. Programs and advocates need to be consistent yet flexible.
4. Establishing a connection based on respect and focusing on an individual's strengths, wisdom, and courage provides the survivor an environment that is supportive and less frightening.
5. The experience of domestic violence violates one's physical safety and security. Programs need to provide safe physical spaces for both adults and child survivors.
6. Emotional safety is imperative so that survivors can feel more secure and comfortable. They need to live in an environment where their worth is acknowledged and where they feel protected, comforted, listened to, and heard.
7. Healing and recovery cannot occur in isolation but within the context of relationships. Relationships fostered with persuasion rather than coercion, ideas rather than force, and empathy rather than rigidity will encourage trust and hope with survivors.
8. When a trauma survivor understands trauma symptoms as attempts to cope with intolerable circumstances, this understanding takes power away from abusers and an individual's abusive experiences.

9. Despite a survivor's experience of abuse, women and children may still feel an attachment to the person who has harmed them.
10. The administration of the agency must make a commitment to incorporate knowledge about trauma into every aspect of service delivery and to revise policies to insure trauma sensitivity.
11. Advocates need to look at the "big picture" and not just view the adult or child victim as only their "behaviors and symptoms."
12. The manner in which a survivor experiences traumatic reactions will certainly be affected by the culture to which she belongs.
13. Collaborating with a survivor places emphasis on survivor safety, choice, and control.
14. Personal boundaries and privacy are inherent human rights.
15. Assume information will need to be repeated from time to time. Survivors of trauma and loss may have difficulty retaining information and processing information.
16. Secondary traumatic stress can cause advocates to lose perspective and slip from understanding to blame.
17. Recognize that institutional barriers are traumatic.
18. Help survivors with coping skills that are simple and intuitive.
19. Recognize that shelter living is traumatic.

National Center on Domestic Violence, Trauma & Mental Health: Trauma-Informed Practice Checklist

This Trauma-Informed Practice Checklist was created by the National Center on Domestic Violence, Trauma and Mental Health. It is a comprehensive checklist that will aid the individual advocate or the domestic violence agency in approaching survivors of domestic violence in a trauma-informed manner. The checklist encompasses critical aspects in connecting and dialoguing with the survivor with sensitivity. The checklist engages the advocate to work with the survivor by addressing the complexities of experiencing domestic violence coupled with the effects of repeated traumas while she is seeking services at your agency. This checklist can be an invaluable tool for advocates, supervisors and administrators who are committed to connecting with women and children victimized by domestic violence.

1. We discussed ways that shelter living can be difficult for everyone and talked about the particular things that would make being here work for her.
_____/_____/_____
2. We discussed the ways we view this shelter as a community and what that means for both residents and staff (i.e. supportive peer environment, shared responsibility, accountability to each other, notions of physical and emotional safety, any rules we have and why we need them, processes for addressing difficulties that arise, concepts of inclusive design and mutual respect)
_____/_____/_____
3. We discussed what kinds of accommodations might be needed for her to feel safe and comfortable in the shelter and developed strategies for making this happen (e.g.) a quiet room, ways to reduce sensory stimulation, relief from certain chores, identification of potential trauma triggers, respite from childcare, addressing issues of stigma, concerns about sleep patterns, lights, locked doors, medication, additional time or repetition to process information, particular kinds of things she might find upsetting, what things are most helpful when she is feeling that way (being alone, having a quiet place to go, listening to music, contact with others, physical contact, no physical contact, ways to check to see if she is really "there" and what might help her reconnect, etc.,).
_____/_____/_____
4. We discussed some of the common emotional or mental health effects of domestic violence and what one can do about them.
_____/_____/_____
5. We discussed the things abusers do to drive or make their partners feel "crazy".
_____/_____/_____
6. We discussed the ways abusers use mental health issues to control their partners.
_____/_____/_____
7. We discussed how she feels the abuse by her partner has affected her emotional well-being and/or mental health.
_____/_____/_____

8. We discussed ways she has changed as a result of the abuse.
_____/_____/_____
9. I asked if she is having any kinds of feelings that concern her.
_____/_____/_____
10. We talked about how many of the things she's experiencing are common responses to abuse.
_____/_____/_____
11. We talked about the links between lifetime trauma, DV, and mental health issues and whether she'd had other traumatic experiences that might be affecting her now.
_____/_____/_____
12. We talked about how a survivor's own emotional responses to abuse can affect how she responds to her children and offered strategies for noticing and addressing those concerns.
_____/_____/_____
13. I assured her that if her responses to any of the abuse or trauma she's experienced caused her suffering or get in the way of things she wants to do then we can help her access additional resources and services.
_____/_____/_____
14. We talked about whether there were any mental health needs or concerns she might want to discuss (re: past interactions with mental health providers/mental health system, treatment medications hospitalizations).
_____/_____/_____
15. I asked if her abusive partner interfered or has attempted to interfere with current or past mental health treatment or medication.
_____/_____/_____
16. We discussed our medication policy and asked her to let us know if she has any particular medication related needs that we could be helpful with (e.g. has run out and needs new supply, is having problems with side effects, is not sure they're helping, she can't afford them/insurance or Medicaid won't cover them, etc.).
_____/_____/_____
17. I provided links to information or resources to help her advocate for herself around medication issues.
_____/_____/_____
18. We discussed her interest in mental health consultation and/or referral and her wishes and concerns about that.
_____/_____/_____
19. While conducting support groups or house meetings at which she was present, I discussed mental health symptoms as being normal responses/adaptations to trauma and abuse.
_____/_____/_____
20. I provided information, support and reassurance if/when she was uncomfortable with the mental health needs of other women in the program.
_____/_____/_____

21. At her request (and with her written consent), I participated in conversations with her and her mental health provider/s about the issues she is facing and informed her mental health providers about domestic violence-specific issues they needed to be aware of, including appropriate documentation; safety and legal issues; abuser accountability and not involving her partner in treatment; the role of advocacy and any additional needed resources and supports.
_____/_____/_____
22. I advocated with mental health providers/systems on her behalf if/when she requested this (and with her written consent).
_____/_____/_____
23. I reflected on my own responses to and feelings about this particular person, where they come from and how they may be affecting me (i.e. vicarious trauma, transference/counter transference, evoking my own experiences of trauma) either privately or with trusted others (including supervisors, peers, family, friends, etc.)
24. I reflected on how my responses might be affecting her.
_____/_____/_____
25. I noticed how difficulties among women in the shelter/agency community affect staff and how difficulties among staff or within the agency, affect women in the shelter/agency community (in general) as well as this particular woman.
_____/_____/_____
26. I noticed instances when tensions among women in the shelter/agency community and staff related to this individual and found supportive ways to discuss this with her.
_____/_____/_____
27. I discussed the process of healing from abuse and other trauma using empowerment-based approaches (e.g. offering a sense of hope; providing information; viewing symptoms as adaptations (strengths based); thinking about what happened to you, not what's wrong with you; offering connection but understanding the effects of experiencing betrayals of trust; discussing "feeling skills" providing information and access to peer support resources).
_____/_____/_____
28. We worked together on strengthening or developing new "feeling skills" (i.e. relaxation training, grounding, affect regulation exercises).
_____/_____/_____
29. We worked on incorporating safety planning into other mental health recovery planning /peer support activities and/or helped her connect with peer support groups.
_____/_____/_____
30. I feel that I have the supervision and support I need to reflect on and respond effectively and empathically to the issues that arise in my work.
_____yes_____no
31. I feel that my agency has created a culture that is welcoming to all survivors; supports openness and communication among both staff and shelter residents; promotes an atmosphere of mutual respect and shared responsibility; is attuned to policies and practices that may be re-traumatizing to survivors (and staff) and has thoughtful and respectful mechanisms in place to address issues as they arise.
_____yes_____no

Citations:

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Resources for Technical Assistance

Tennessee Coalition to End Domestic & Sexual Violence
www.tncoalition.org

National Center on Domestic Violence, Trauma & Mental Health
http://www.nationalcenterdvtraumamh.org/

End Violence Against Women International www.evaw.org

Sexual Assault Training & Investigations http://www.mysati.com/publications.htm

RAINN www.rainn.org

SART Tool Kit http://ovc.ncjrs.gov/sartkit/index.html

Violence Against Women Online Resources http://www.vaw.umn.edu/

American College Health Association campus violence resources
http://www.acha.org/Topics/violence.cfm

Faith Trust Institute http://www.faithtrustinstitute.org/

National Sexual Violence Resource Center http://www.nsvrc.org/

Office on Violence Against Women http://www.ovw.usdoj.gov/sexassault.htm

AEQUITAS prosecutor's resource http://www.aequitasresource.org/

Men Can Stop Rape http://www.mencanstoprape.org/index.htm

National Alliance to End Sexual Violence http://naesv.org/

Resource Sharing Project http://resourcesharingproject.org/

National Online Resource Center on Violence Against Women
http://www.vawnet.org/sexual-violence/

Pennsylvania Coalition Against Rape http://www.pcar.org/

Oregon Sexual Assault Task Force http://oregonsatf.org/

National Institute of Justice -
http://www.nij.gov/nij/topics/crime/rape-sexual-violence/other.htm

Prison Rape Elimination Act Resources
http://www.ojp.usdoj.gov/programs/prisonrapeelimination.htm