



Trauma-Informed Therapy: Ethical Considerations

Presented by Dreya Blume, LCSW



OBJECTIVES

- **Describe the components of an ethical trauma-informed practice**
- **Recognize how to best serve their clients who have a trauma history**
- **Formulate a plan to ensure that clients feel safe during the therapy session**
- **Apply a series of steps to minimize client triggering during session**



Trauma decontextualized in a person looks like personality.

Trauma decontextualized in a family looks like family traits.

Trauma in a people looks like culture.

Resmaa Menakem

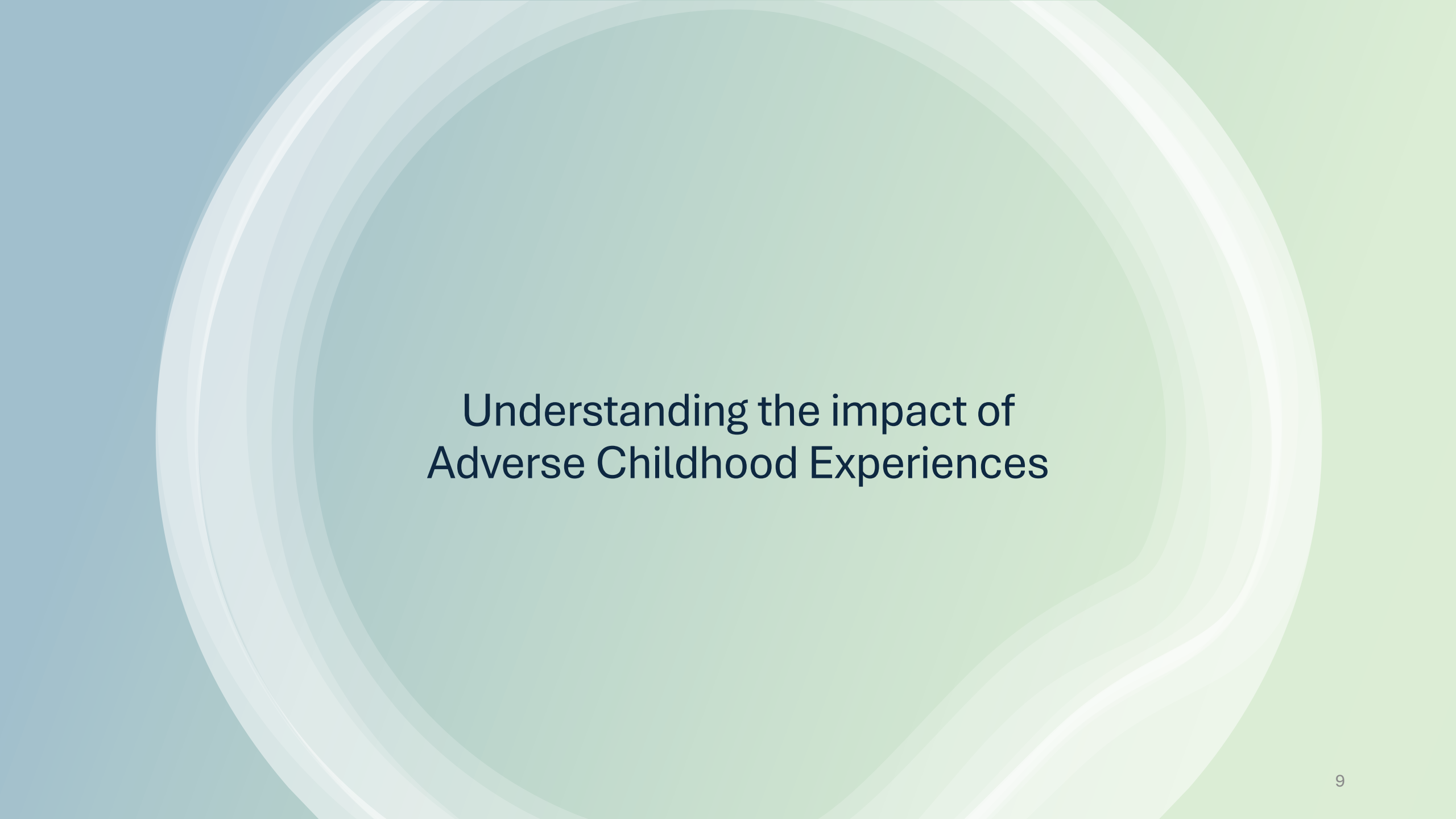
The purpose of ethics

Do No Harm



Why trauma-informed care is vital

Looking at the connection
between trauma history and
current symptoms



Understanding the impact of Adverse Childhood Experiences

How to be a trauma-informed therapist

Educate Yourself About Trauma

Continuously educate yourself about trauma, its effects on the brain and body, trauma-related disorders (e.g., PTSD, complex PTSD), and different trauma types (e.g., childhood trauma, sexual abuse, emotional neglect).



Understanding how trauma impacts the brain

A traumatic event can significantly alter the brain's structure and function. Here's an overview of the key changes that may occur:



Amygdala (Fear and Emotional Response Center)

Increased Activity: The amygdala is responsible for detecting fear and preparing the body for emergency responses. After trauma, it can become hyperactive, leading to heightened fear, anxiety, and hypervigilance. This means the brain may stay on high alert, even in non-threatening situations.

Hippocampus (Memory and Learning)

Shrinking or Dysfunction: The hippocampus plays a critical role in processing and storing memories. Trauma can cause the hippocampus to shrink or function poorly, leading to difficulties in distinguishing between past trauma and current experiences. This often results in flashbacks, dissociation, and difficulty recalling aspects of the traumatic event.



Prefrontal Cortex (Rational Thought and Decision-Making)

Reduced Function: Trauma can impair the prefrontal cortex, which is responsible for regulating emotions, decision-making, and reasoning. This can lead to impulsivity, poor emotional regulation, and difficulty in controlling fear responses. As a result, trauma survivors may struggle with focusing or thinking clearly in stressful situations.



Stress Hormone Imbalance

Overactive Stress Response (HPA Axis): Trauma can cause the hypothalamic-pituitary-adrenal (HPA) axis to become overactive, leading to the constant release of stress hormones like cortisol and adrenaline.

While these hormones are helpful in emergencies, chronic elevation can damage the brain and body over time, contributing to anxiety, depression, and other health issues.



Neuroplasticity and Recovery

Rewiring for Survival: The brain is highly plastic, meaning it can adapt and change in response to experiences.

After trauma, the brain may rewire itself in ways that prioritize survival—this can include heightened sensitivity to potential threats or triggers.

While some changes are adaptive, they can also lead to maladaptive patterns like avoidance or hyperarousal.



A traumatic event can have profound effects on the body's nervous system, particularly through the autonomic nervous system (ANS), which controls involuntary bodily functions like heart rate, digestion, and respiratory rate.

The ANS has two main branches—the **sympathetic** nervous system (SNS) and the **parasympathetic** nervous system (PNS)—which respond to trauma in different ways.

Sympathetic Nervous System (SNS) Activation

The SNS is responsible for the body's "fight-or-flight" response, and trauma can cause it to become hyperactive.

- **Fight-or-Flight Response:** During a traumatic event, the SNS triggers the release of stress hormones (adrenaline, cortisol) to prepare the body to either fight or flee. This can lead to:
 - Increased heart rate and blood pressure
 - Rapid breathing (hyperventilation)
 - Dilated pupils
 - Muscle tension
 - Suppressed digestion (dry mouth, upset stomach)
- **Prolonged Activation:** After trauma, the SNS may stay activated, even in non-threatening situations, causing chronic stress responses such as hypervigilance, irritability, and difficulty calming down. This is often seen in people with **Post-Traumatic Stress Disorder (PTSD)**, where the nervous system remains on high alert.

Parasympathetic Nervous System (PNS) Shutdown

The PNS is responsible for the "rest-and-digest" response, helping the body to relax and recover. In response to trauma, the PNS can either be underactive (unable to calm the body) or, in extreme cases, over-activated in a negative way.

Overactivation and Shutdown: In some traumatic experiences, especially those where escape or fight isn't possible, the body may trigger a **freeze** or **collapse** response. This leads to a parasympathetic overactivation, where the person may experience:

- Numbness or dissociation
- A sense of immobilization or paralysis
- Lowered heart rate and blood pressure
- Feeling detached from reality or the body This is the body's way of conserving energy or protecting itself when it perceives no way to fight or escape.

HPA Axis and Chronic Stress

The **hypothalamic-pituitary-adrenal (HPA) axis** is a critical part of the body's stress response system, regulating the release of cortisol and other stress hormones. Trauma can cause the HPA axis to become dysregulated, leading to:

- **Chronic Stress State:** Continuous high levels of cortisol and adrenaline can wear down the body, contributing to anxiety, insomnia, immune dysfunction, and even heart disease.
- **Exaggerated Responses to Stress:** Even minor stressors can trigger extreme nervous system responses, making everyday situations feel overwhelming.

Vagus Nerve Involvement

The **vagus nerve** plays a key role in the parasympathetic nervous system and is essential in regulating relaxation and digestion. Trauma can impair the functioning of the vagus nerve, reducing the body's ability to return to a calm state after stress.

Dysregulated Vagal Tone: Poor vagal tone can lead to symptoms like chronic anxiety, difficulty calming down, and problems with digestion. Techniques like deep breathing, meditation, and physical exercise can help improve vagal tone and restore balance in the nervous system.



Somatic Symptoms

Trauma can also manifest in physical symptoms through the nervous system. These include:

- **Muscle Pain and Tension:** The body can store trauma, leading to chronic muscle tension or pain, especially in areas like the neck, shoulders, and back.
- **Digestive Issues:** The nervous system's dysregulation can lead to issues like irritable bowel syndrome (IBS), nausea, or loss of appetite.
- **Headaches:** Stress and tension from trauma can cause tension headaches or migraines.



Dysregulated Sleep and Rest Cycles

Trauma can disrupt the balance between the SNS and PNS, leading to difficulties in sleeping or staying asleep. This is because the body may struggle to downregulate and shift into a restful state due to ongoing hyperarousal.



Social Engagement System

Trauma can impair the ability of the **social engagement system**—regulated by the ventral vagal complex (part of the PNS)—which helps individuals feel safe in relationships and socially connected. As a result, people may experience social withdrawal, difficulty trusting others, or feeling disconnected from those around them.

Trauma can be stored in the body in various ways, affecting not just the mind but also the physical self.

The idea that trauma is "stored" in the body means that unprocessed emotional experiences from a traumatic event manifest physically, influencing muscle tension, posture, organ function, and even overall health.

Here's how trauma is stored and how it manifests in the body:

Muscle Tension and Chronic Pain

- **Fight, Flight, or Freeze Response:** During trauma, the body's natural fight, flight, or freeze response involves muscle activation—either to prepare the body for action (fight/flight) or to immobilize it (freeze). When trauma isn't fully processed, the body may hold onto that response, leading to chronic muscle tension. This can manifest as tightness in the shoulders, neck, back, or jaw.
- **Muscle Memory:** The body can develop muscle memory from the trauma, meaning certain movements or postures can trigger emotional or physical responses associated with the original event. This might include tension, pain, or a sense of discomfort when in certain positions or environments.

Fascia (Connective Tissue)

- **Fascial Tightness:** The fascia is a web of connective tissue that surrounds muscles and organs. Some researchers and bodywork practitioners believe that the fascia can hold tension and emotional memories from trauma. When the body experiences emotional or physical trauma, this tissue can tighten and form adhesions, leading to restricted movement and chronic pain.

Autonomic Nervous System Imbalance

- **Hyperarousal:** If trauma leads to long-term sympathetic nervous system (SNS) activation (fight-or-flight), the body remains in a state of heightened alertness. This constant stress can result in symptoms like an increased heart rate, shallow breathing, digestive issues, and difficulty relaxing.
- **Hypoarousal (Freeze State):** In cases where trauma leads to a freeze response (immobilization), the parasympathetic nervous system (PNS) can become overly activated, causing numbness, disconnection from the body, and difficulty feeling emotions. This can lead to feelings of physical exhaustion, low energy, and dissociation from bodily sensations.

Stored in Organs (Visceral Reactions)

- **Gut-Brain Connection:** The enteric nervous system (sometimes called the "second brain") in the gut is highly sensitive to stress and trauma. Trauma can cause or exacerbate digestive issues such as irritable bowel syndrome (IBS), bloating, and nausea. This is because the gut is closely linked to the nervous system and responds to emotional states like anxiety, fear, or sadness.
- **Heart and Chest:** Emotional trauma, especially grief or fear, can create a physical sensation of heaviness or tightness in the chest. Over time, this can contribute to stress-related heart conditions.
- **Lungs and Breathing:** Shallow or rapid breathing is a common response to trauma, often because the body remains in a "fight or flight" mode. This can lead to chronic issues like shortness of breath, hyperventilation, or feelings of suffocation.

Dissociation from Bodily Sensations

- **Emotional Numbing:** In response to trauma, some individuals may experience a disconnection from their body, feeling numb or out of touch with physical sensations. This is a defense mechanism that helps to "shut down" feelings of pain or fear. However, dissociation can become chronic, leading to difficulties in feeling emotions or being aware of physical states like hunger, pain, or fatigue.
- **Body Dissociation and Trauma Memories:** Some trauma survivors may feel as though their body is not theirs or as if they are outside of their body. This disconnection can prevent them from fully processing traumatic memories, leading to unprocessed emotions being held in the body.

Somatic Flashbacks

- **Physical Memory of Trauma:** Trauma can lead to somatic flashbacks, where the body re-experiences physical sensations associated with a past traumatic event.

These are not just mental recollections but involve physical reactions like pain, tightness, or nausea, triggered by certain stimuli or emotional states.

For example, the body might reenact the same tension or posture from the original trauma, even if the memory is not consciously present.



Breathing Patterns

Shallow or Restricted Breathing: Traumatic events can alter breathing patterns, making individuals more prone to shallow breathing.

This can happen because the body is preparing for fight or flight or because of a freeze response where breathing is restricted.

Over time, this shallow breathing becomes habitual and can reinforce feelings of anxiety, panic, or stress.



Emotional and Physical Triggers

- **Somatic Triggers:** Certain bodily sensations can trigger trauma memories or emotional responses.

For example, a specific type of touch, a certain posture, or even the way the body feels in a particular environment can activate stored trauma.

This can lead to sudden emotional reactions, muscle tension, or physical discomfort, seemingly unrelated to the present moment.

Energy and Fatigue

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graph TD; A[Energy and Fatigue] --> B[Low Energy and Fatigue: Trauma can drain the body's energy reserves, as the nervous system is often in a heightened state of alertness (hyperarousal) or collapse (hypoarousal). This can manifest as chronic fatigue, sleep disturbances, and difficulty recovering from stress. The body may feel perpetually tired as it attempts to cope with the unresolved trauma.]; B --> C[Overactivation (Hyperarousal): Alternatively, some people might experience bursts of hyperenergy or agitation, where they feel the need to constantly stay busy or on the move. This can be a way to avoid processing trauma but often leads to burnout and exhaustion over time.];
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Posture and Movement

- **Postural Changes:** Trauma can change a person's posture. For example, someone who has experienced emotional or physical trauma may unconsciously hunch their shoulders or tense their body to protect themselves, leading to physical imbalances.
- **Restricted Movement:** Trauma may also cause a person to restrict their physical movement. This can happen as a protective mechanism, where the body tries to avoid sensations or actions that may trigger emotional pain. This can result in stiffness or reduced mobility in parts of the body.

Memory

Implicit memory is a type of long-term memory that involves the unconscious retention of information, influencing thoughts and behaviors without explicit awareness.

It encompasses skills and procedures, such as riding a bike or playing a musical instrument, as well as conditioned responses and priming effects, where exposure to one stimulus influences the response to another.

Unlike **explicit memory**, which involves conscious recall of facts and events, implicit memory operates automatically, allowing us to perform tasks and learn new skills without having to actively think about them.

Memory

Trauma blocks explicit processing and heightens implicit processing. This means that conscious recall is inhibited while sensory recall is heightened.

Trauma limits the function of the hippocampus (due to increased cortisol), disrupts the consolidation of explicit memory and activates the amygdala (leading to release of adrenaline which intensifies implicit memory).

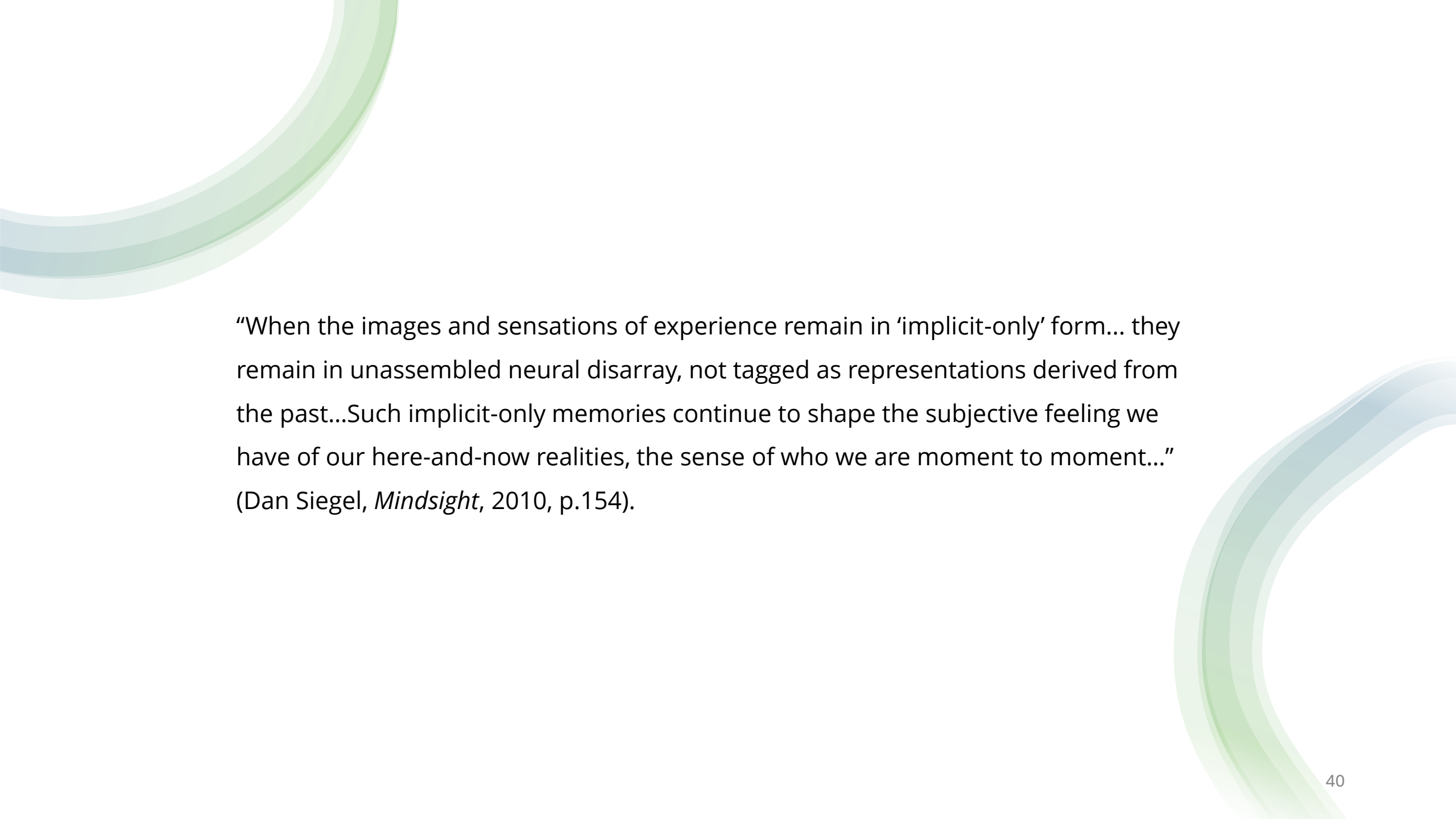
The maintenance of PTSD [relates] to the failure of sensory information to become contextualized and integrated with normal continuous autobiographical memory, a process associated with reductions in distressful reexperiencing.

This failure to contextualize is partly related to disruptions in the encoding of episodic memory at times of extreme stress, rendering volitional recall of the traumatic experience fragmented, disorganized, poorly elaborated, not integrated into time and place, and incomplete.

Elevated physiological arousal interferes with conceptual processing of episodic memory, impairing abstraction and meaning-making. This cognitive information processing model of PTSD also underscores how memory processing deficits contribute to cognitive appraisals of trauma that contribute to the persistence of the disorder.

The Role of Implicit Memory in the Development and Recovery from Trauma-Related Disorders

by **Louis F. Damis** (<https://www.mdpi.com/2673-4087/3/1/5>)



“When the images and sensations of experience remain in ‘implicit-only’ form... they remain in unassembled neural disarray, not tagged as representations derived from the past...Such implicit-only memories continue to shape the subjective feeling we have of our here-and-now realities, the sense of who we are moment to moment...”
(Dan Siegel, *Mindsight*, 2010, p.154).

Memory interference

In normal situations, our brain stores an event in both implicit and explicit memory systems (in the thinking brain and emotional brain). But since the amygdala hijacks the thinking brain when we experience intense fear, our thinking brain's ability to store the traumatic event's details is thwarted too. As a result, the traumatic event is encoded only in implicit memory (the emotional brain).

Triggers

This means that our feelings and sensations of the traumatic event are stored but not the language or context. So anything that reminds us of the trauma can automatically trigger the emotions associated with the traumatic experience without the sense-making input of the thinking brain. As a result, we may feel anxious in new situations and but not know why.

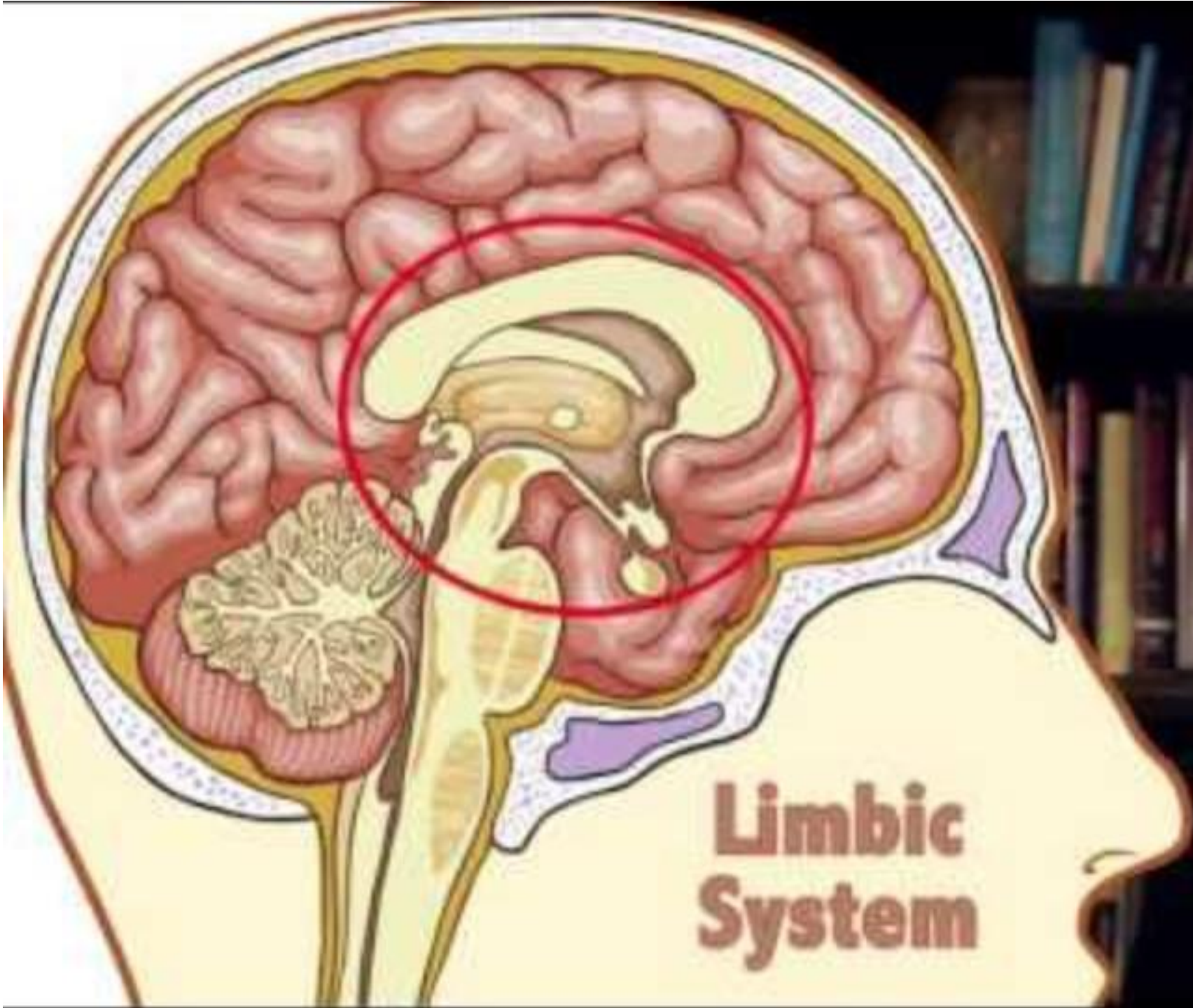
Dr. Jena Field

<https://themonkeytherapist.com/science-behind-traumatic-memories/>

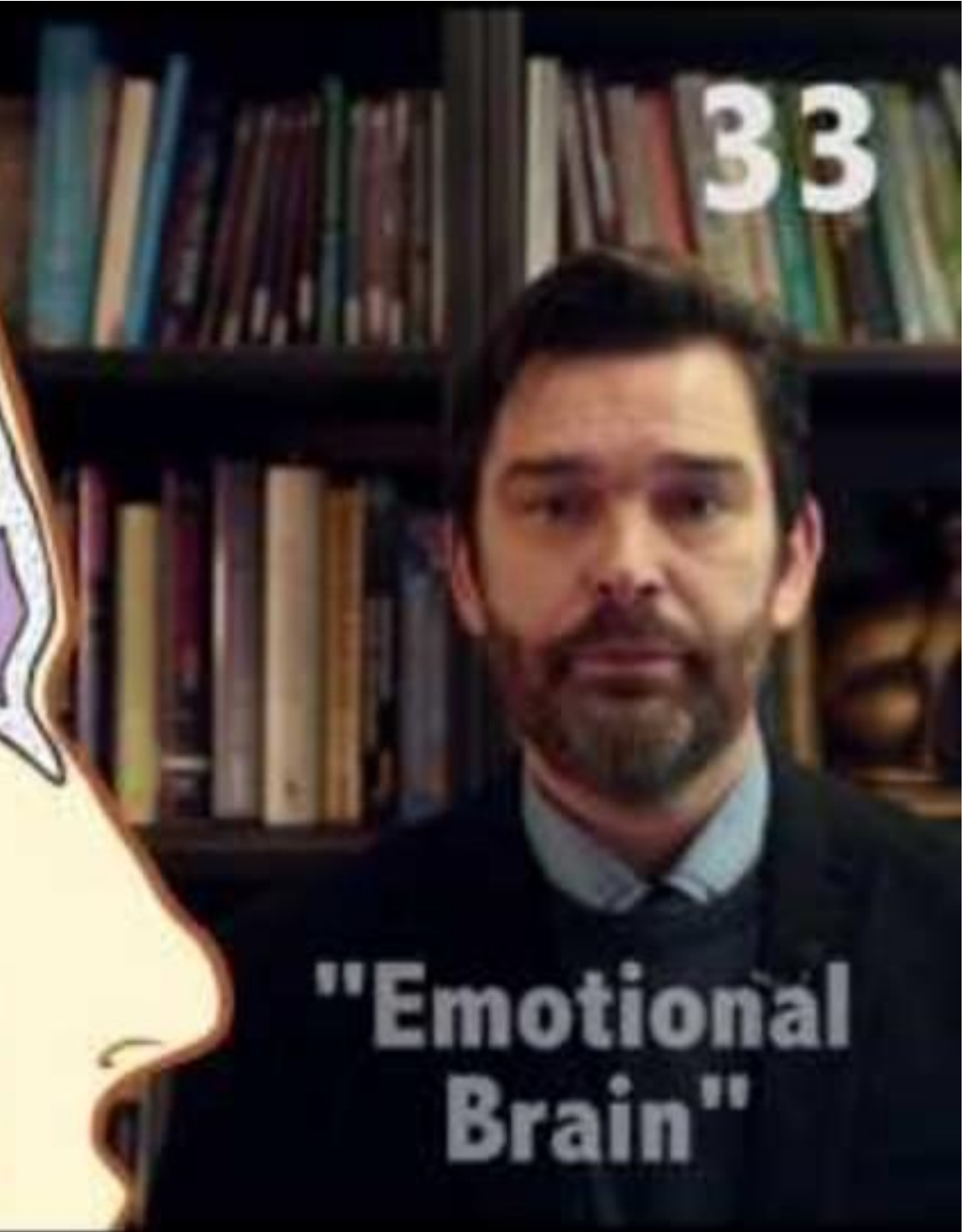
Video:

The Science of Psychotherapy YouTube Channel


<https://youtu.be/7uVSGbnEH0g>



Limbic System



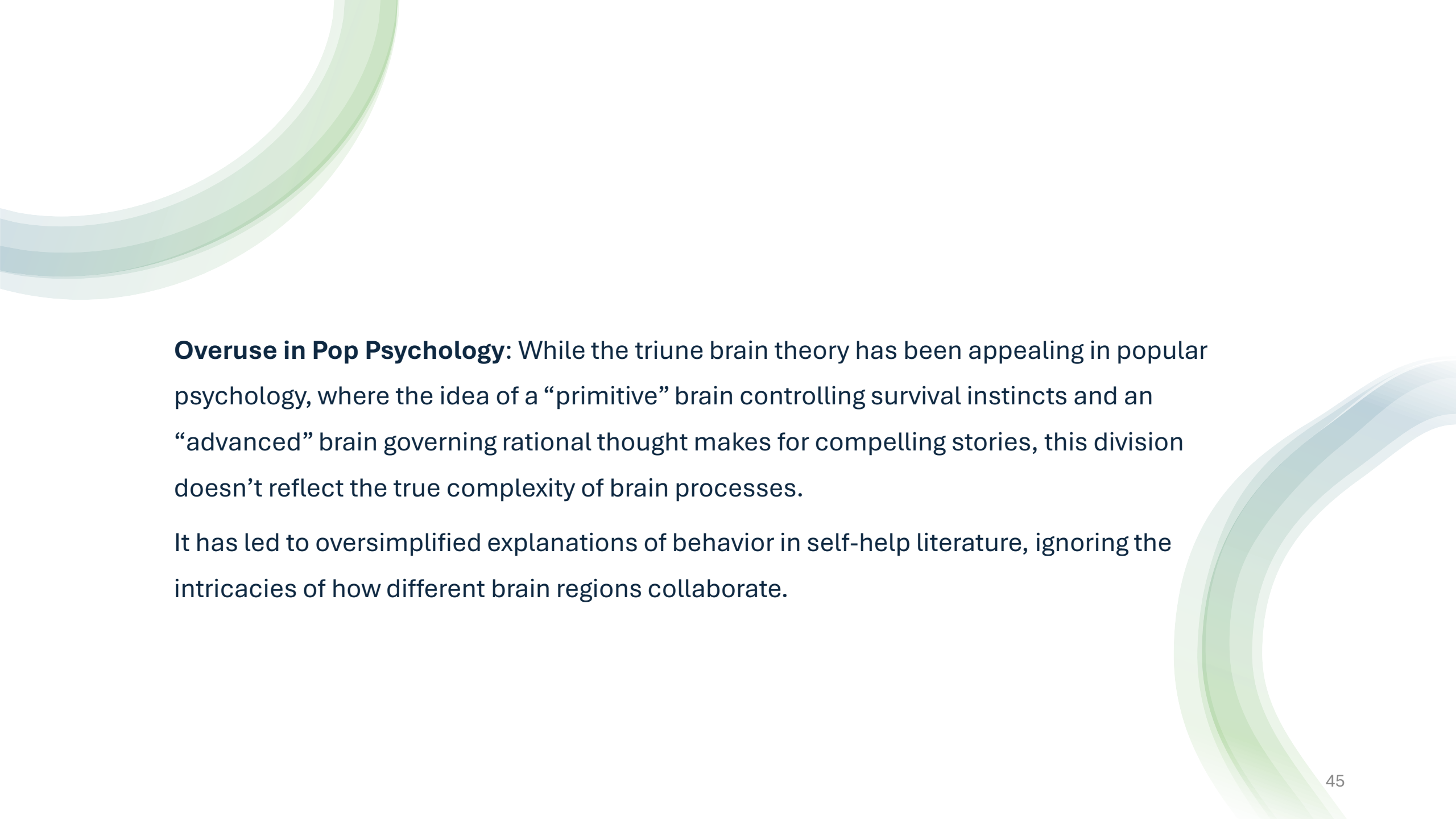
"Emotional Brain"



While the **triune brain theory** provided an influential framework for understanding the brain's evolution and functions, it has been widely critiqued for oversimplifying the brain's structure and function.

Modern neuroscience has demonstrated that brain regions work in complex, interconnected ways, and the brain's evolution was not as linear or divided as MacLean's theory suggests.

The theory remains valuable as a historical perspective and metaphor, but it is largely outdated in the context of contemporary brain science.



Overuse in Pop Psychology: While the triune brain theory has been appealing in popular psychology, where the idea of a “primitive” brain controlling survival instincts and an “advanced” brain governing rational thought makes for compelling stories, this division doesn’t reflect the true complexity of brain processes.

It has led to oversimplified explanations of behavior in self-help literature, ignoring the intricacies of how different brain regions collaborate.



Simplistic Models in Education: The theory has been used in educational settings to explain learning processes, but it may oversimplify the interplay between emotional and cognitive development.

Modern neuroscience suggests that learning involves a more dynamic interaction between emotional states, social contexts, and higher cognitive functions, not a strict division between the "emotional" and "rational" brain.

Misleading Separation of Rationality and Emotion

- **Integration of Emotion and Reasoning:** The triune brain theory implies that rationality (neocortex) and emotions (limbic system) operate separately. However, emotion and cognition are deeply intertwined.

For example, decision-making processes rely heavily on emotional input, and emotions are influenced by rational thought. Brain regions like the **prefrontal cortex** and the **amygdala** work together to regulate emotional responses in a rational context.

- **Single Emotional Center Fallacy:** Emotions are not solely the domain of the limbic system. Complex emotions like empathy, guilt, and social behavior are processed by networks involving the neocortex and other areas, not just the amygdala or hippocampus (parts of the limbic system). This undermines the notion of the limbic system being an "emotional brain."



Scientific Inaccuracy of Brain Layers

- **No Clear Distinction Between Layers:** The triune brain theory suggests that there are distinct layers in the brain that evolved separately. However, modern brain imaging and studies of brain anatomy reveal no clear separation between the so-called "reptilian," "limbic," and "neocortical" areas. These regions overlap and interconnect in complex ways, undermining the idea of distinct, functionally isolated "brains."
- **Shared Features Across Species:** Many of the structures MacLean attributed to humans or higher mammals are found in various forms in other species. For instance, birds, which MacLean suggested lacked a neocortex, actually possess brain structures capable of complex problem-solving and social interactions, revealing that brain evolution isn't as stratified as the triune model suggests.

The "Reptilian Brain" Misconception

- **Flawed Concept of the Reptilian Brain:** MacLean's theory suggests that the brainstem and basal ganglia, which he termed the "reptilian brain," control basic survival functions like aggression, dominance, and territoriality.

However, these structures are not exclusive to reptiles and exist in all vertebrates, including mammals.

Moreover, modern neuroscience shows that complex behavior like aggression and territoriality involves higher brain regions, including the neocortex, not just the "reptilian" structures.

- **Behavioral Complexity in Reptiles:** The term "reptilian brain" falsely implies that reptiles are purely instinct-driven creatures. Research has shown that reptiles can exhibit more complex behavior, including problem-solving and social interactions, which are not fully accounted for in the triune model.

Inaccurate Functional Divisions

Interconnectedness of Brain Functions: The triune brain theory suggests that each part of the brain has its own distinct set of functions (survival, emotions, rational thought), but neuroscience research shows that the brain is highly interconnected.

The reptilian brain (brainstem), limbic system, and neocortex constantly interact with one another. Emotions are not confined to the limbic system, and rational thinking isn't isolated to the neocortex; both rational and emotional processing occur across multiple brain regions.

Complexity of Emotion and Cognition: The idea that the neocortex is responsible solely for rational thought and the limbic system for emotion is an oversimplification. Higher-level cognition (e.g., decision-making, planning) and emotional processing occur in both regions. For instance, the prefrontal cortex, part of the neocortex, is deeply involved in emotional regulation, not just rational thought.

Oversimplification of Brain Evolution

- **Linear Evolutionary Model:** The triune brain theory suggests that the human brain evolved in a linear, stepwise fashion, with each layer being added in sequence (first the reptilian brain, then the limbic system, and finally the neocortex).

However, modern evolutionary biology shows that brain evolution is much more complex. Instead of clear-cut stages, brain structures evolved in a more integrated and overlapping way across different species.

- **Continuity of Evolution:** The idea that certain structures are "primitive" and only seen in reptiles or early mammals is inaccurate. All vertebrates, including reptiles, birds, and mammals, have some form of a limbic system and even more developed regions of the cortex. Thus, no part of the brain can be entirely tied to a single evolutionary period.

Live learners, according to the approving body, it is time for you to take a quick 15-minute break!

For our online learners, we have provided a video for you to watch to continue your learning through the breaktime. This is a little over 15 minutes so it will roll into the time when live learners return. Live learners, you are welcome to stay and watch!



Video

Dr. Tori Olds

https://youtu.be/PWfpLtgxDi4?si=km0_g97BwpSPW2pK



MEMORY RECONSOLIDATION

What can we do as clinicians?



Create a Safe and Predictable Environment

Ensure that the therapy space feels physically and emotionally safe.

The room should be quiet, comfortable, and free of distractions.

Establish a predictable routine for sessions so clients know what to expect.

Emphasize Client Safety and Control

From the outset, emphasize the client's control over the therapy process.

Reaffirm that they can stop or slow down the session if they feel overwhelmed.

Encourage clients to communicate their comfort level with certain interventions.



Use a Strengths-Based Approach

Focus on the client's strengths and resilience rather than just the trauma they've experienced.

Highlighting their ability to cope and survive helps foster empowerment and healing.

Always look for 'exceptions'



Practice Active Listening and Validation

Actively listen to your client's story without judgment. Validate their feelings and experiences, acknowledging the difficulty of what they've gone through, which reinforces a sense of safety and respect.

Avoid Re-Traumatization

Be mindful not to push the client into discussing traumatic events too soon or in too much detail.

Trauma processing must happen at a pace that feels safe and manageable for the client.



Establish Clear Boundaries

Clearly communicate boundaries, both relational and professional.

Establishing predictable roles and limits can help build trust and a sense of security.

Collaborate and Empower

Work collaboratively with clients by encouraging their active participation in decision-making.

This can include setting therapeutic goals, deciding on techniques, and pacing of sessions.

Empowering the client fosters autonomy and healing.





Focus on Stabilization First

Prioritize stabilization, emotional regulation, and grounding techniques before delving into trauma processing.

This could include mindfulness, relaxation exercises, or breathing techniques to help the client manage distress.

Be Mindful of Triggers

Take care to avoid triggers (e.g., certain words, body language, or topics) that may inadvertently activate traumatic memories.

Ask clients what their triggers are and remain sensitive to subtle signs of discomfort.



Trauma-Sensitive Language

Use language that is non-judgmental, neutral, and trauma-sensitive.

Avoid pathologizing terms or implying blame. Frame conversations in ways that encourage self-compassion.



Be Attuned to Nonverbal Cues

Pay attention to nonverbal cues, such as body language, tone of voice, or shifts in posture.

These can indicate when a client feels unsafe or overwhelmed, even if they don't verbalize it.

Respect Client Autonomy

Respect the client's autonomy at all times.

Never force them to talk about something before they're ready.

Allow them to set the pace of therapy and determine what they feel comfortable discussing.



Understand the Body's Role in Trauma

Trauma often manifests physically, so be familiar with body-based symptoms and somatic responses.

Incorporate somatic awareness techniques (e.g., body scanning, mindful breathing) to help clients reconnect with their bodies safely.



Cultural Sensitivity

Be mindful of the client's cultural, racial, gender, and sexual orientation background, and how these factors may intersect with their trauma. A culturally sensitive approach can prevent further harm and ensure that therapy feels inclusive and respectful.



Pace the Therapy Appropriately

Recognize that trauma work is often slow and gradual.

Avoid rushing the client or trying to “fix” them quickly.

Trauma processing can take time, and the pace should be client-led.



Address Power Dynamics

Be mindful of the inherent power dynamics in the therapist-client relationship.

Actively work to reduce power imbalances by being transparent about treatment, offering choices, and respecting the client's perspective.

Provide Psychoeducation

Educate clients about the impact of trauma on the brain and body, normalizing their responses and helping them understand their symptoms. This can reduce shame and increase their sense of control over their healing process.

Foster Self-Compassion

Help clients develop self-compassion by reframing their trauma responses (e.g., fight, flight, freeze) as adaptive coping mechanisms, not personal failings.

Encourage a compassionate attitude toward their struggles and emotions.

Engage in Regular Self-Care and Supervision

Acknowledge the emotional toll that trauma work can take on therapists.

Engage in regular self-care, seek supervision or consultation when needed, and maintain your own emotional well-being to avoid burnout and ensure high-quality care for clients.

I get that it's lost meaning in many ways, but to me being trauma-informed means applying a lens that trauma influences healing not just in our approach to therapy, but in literally every way we approach doing therapy.

For example in private practice, taking things such as the location of the practice, the waiting area, the approach to intake paperwork, the various practice policies, etc. would all be determined after actively thinking through a trauma-informed lens.

Would it be more efficient to hand a stack of papers to a client (or email them) for intake?
Probably.

Does this approach take into account those clients who may have trauma surrounding former therapy intakes, those with poor capacity to read/understand written language, those who find the medical approach to therapy as a traumatizing reminder of early experiences with psychiatry in general?

[Jnnjuggle32, a therapist, on Reddit](#)



From: r/TalkTherapy (Reddit)

Patient perspectives on psychotherapy

Topic: *“What do you need to feel safe in therapy?”*

Trust.

Time. Time to settle. Time to reveal myself. Time to feel contained.

Consistency. Of sessions. Of my therapist's responses and affect.

Acceptance.

Boundaries that are held firmly but flexibly.

The freedom to fidget, hold my legs against my chest, scratch a little, stare off into space after they ask me something, judgement free awkward silence, their relevant questioning when I run out of things to say.

I've had only one therapist that was reliably competent, ethical and empathetic. She was genuinely warm, had overall good consistent boundaries (with exception that she was chronically late, but so was I and our lateness dovetailed nicely), she had a wide life experience so was never surprised by my stories, she was unfailingly encouraging but also was not afraid to challenge me.

I was quite attached to her but because of her clear boundaries I never forgot that she was my therapist and that I needed to find friends in real life and not just rely on her for my social needs.

She was also fond of my questions, and even occasional anger and did not lash out or react with contempt to polite questions like nearly every other therapist I've seen.

A long time. Consistency.

I'm a little over a year with him.

He takes me seriously

He starts our session exactly on time.

He remembers what we talked about

He trusted me.

I had bad SI but I said I wouldn't act on it. He acknowledged the pain but didn't make me go to the hospital and said he took my word for it.

I need to trust that my therapist can discern between talk about chronic suicidal ideation and a crisis that needs intervention.

My current therapist is probably the person I've trusted most to discuss these thoughts. Hell, it was just within the last hour that she first used the phrase "chronic suicidal ideation."

She makes me feel safe to discuss my struggles whereas other T's have made me feel like I have to constantly reassure them I'm safe so I don't get grippy socked.

I also want to feel like I'm not my T's entertainment.

I spent a short time with a T who may as well have been eating popcorn while listening to my anecdotes.

She even said, "This is like a tv show!" I wasn't able to bring myself to return after that.

Time

Compassion

Silence

Permission to change my mind

Honest/authentic feeling responses

A feeling that the therapist is not trying to push any particular agenda

I am disabled and Queer so I also need a therapist who is educated about

disability justice and knowledgeable about the Queer community

I am in recovery from an eating disorder, so fat activism is also important to me.

I also appreciate that none of my therapists have been strict about how or where I sit, or what I'm doing during therapy.

For a while with my first therapist we would sit at a table together and color, and slowly stopped doing that as I was able to open up more comfortably without a barrier/distraction. I've also eaten in therapy or messed with fidget toys the whole time. I typically sit cross-legged too, with my shoes off and hugging a pillow.

All of them have taken my perceptions/ideas of my own diagnoses (or sometimes, my family's diagnoses) with respect and fair consideration. I've brought up bipolar disorder, autism, schizophrenia, and personality disorders, just to name a few, and none of them have been super quick to tell me "that's not true", but have instead been like "okay, why do you think that? Talk me through your thoughts, we can look at this together".

Cont' on next slide....

Also!!! Not being offended when I ask them questions.

Like why they said something to me, why they reacted the way they did, their decisions about my diagnoses, etc. I have a lot of anxiety surrounding people's perceptions of me, so it's nice to have that honesty from them without hostility.

- easy, clear access to the door
- an outside view so I can resource
 - my stuffed animal
- space to get up, walk around, lay down, etc
- my T to remind me from time to time that I'm in control, in charge, that I'm safe here

SAMHSA

Six components of Trauma-Informed Care

- 1) Safety
- 2) Trustworthiness and transparency
- 3) Peer support
- 4) Collaboration and mutuality
- 5) Empowerment, voice and choice
- 6) Cultural, historical and gender issues

From “Trauma-Informed Care in Behavioral Health Services” (book published by SAMHSA)

- Work with the client to learn the cues he or she associates with past trauma.
 - Obtain a good history.
 - Maintain a supportive, empathetic, and collaborative relationship.
 - Encourage ongoing dialog.
- Provide a clear message of availability and accessibility throughout treatment.

**From “Trauma-Informed Care in Behavioral Health Services”
(book published by SAMHSA)**

“Beyond anticipating that various environmental stimuli within a program may generate strong emotions and reactions in a trauma survivor (e.g., triggers such as lighting, access to exits, seating arrangements, emotionality within a group, or visual or auditory stimuli) and implementing strategies to help clients cope with triggers that evoke their experiences with trauma, other key elements in establishing a safe environment include consistency in client interactions and treatment processes, following through with what has been reviewed or agreed upon in sessions or meetings, and dependability.”

compassion fatigue

“Compassion fatigue (CF) is an empathetic reaction resulting from frequently witnessing the emotional or physical suffering of others or repeatedly listening to a person suffering from mental or physical dysfunction”

(L. Zhang, et al.)

Burnout:

Feelings of exhaustion

Negative or cynical attitudes towards work

A sense of not doing well or not being effective in one's work

How to prevent compassion fatigue

Sleep

Nutrition

Relaxation

Movement

Peer support

Boundaries

Regular time off

Where can you operate less than at 100% and be okay with it?



Being aware of countertransference

Processing what is coming up for us

Serenity prayer

Higher Power

Grant me the serenity to accept

What I cannot change

The courage to change what I can

And the wisdom to know the difference

Leaving it “at the office”

Final Questions?

Books

101 Trauma-Informed Interventions, by Linda Curran

Trauma-Focused Acceptance and Commitment Therapy, by Russ Harris

Principles of Trauma Therapy, by John Neale Briere

The Body Keeps the Score, by Bessel Van der Kolk

It Didn't Start with You, by Mark Wolynn