So, what is Trauma-Informed anyway?

As the resident psychologist at Te Puaruruhau, Te Whatu Ora Child Protection service at Te Toka Tumai, Auckland, I am often asked, "*What do I have to do to be trauma-informed?*"

Let me try to explain.
Becoming trauma-informed is a journey with no destination to arrive at. And perhaps the success of the journey is more about who comes along with you, the occasional detours you take, and the people you meet on the way. It is a journey where the landscape changes constantly; one that is led by research but with new challenges and dialogue constantly confronting us. And there's no one size-fits-all when it comes to what works. Because it depends on your group, your ancestry, your context, community, geographical location, what is happening at the time you are living and what is happening to the people you are serving. It is less about what is done and more about how you behave.

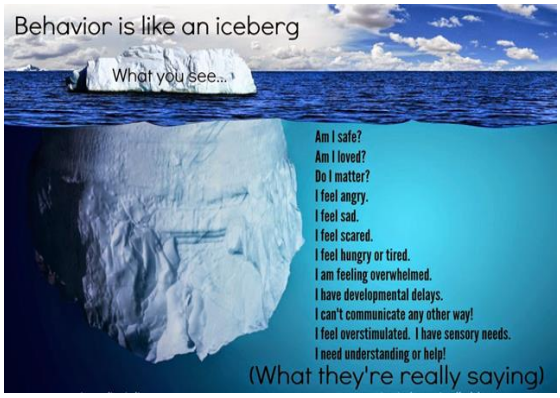
Trauma Informed Care (TIC) is not rocket-science! It is a discipline that requires us as clinicians to look beyond what we see in our clients and consider something else; their story. We need to '**Stop asking what's wrong, and Start asking what's happened'**.

Part of being trauma-informed is understanding about ACEs (Adverse Childhood Experiences); that study of 17,000 people in San Diego in the late 1990s that explored the association between childhood experiences and lifelong health. They discovered the more ACES someone had, or the more adversities they had experienced, the more at risk they were for poorer outcomes for health and wellbeing compared to someone with no ACES. They also discovered that ACEs were cumulative and dose-dependent. The risk for poor health outcome went up for each additional adverse experience in childhood. Nadine Burke-Harris, California's first Surgeon General, says that "*the single most important thing we need today is the courage to look this problem in the face and say – this is real and this is all of us."*

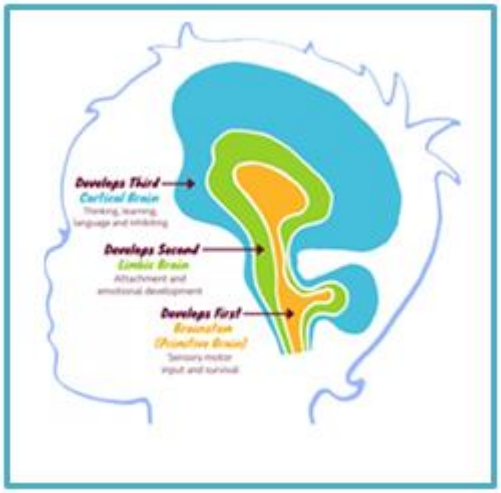
Trauma is both an event and a response to an event. It is our response to that event that makes something 'traumatic' or not. Responses to trauma are not ubiquitous and instead are highly subjective. What might upset or anger some people, might be simply brushed aside and understood by others as a manageable road-bump. We are not better or worse for how we respond. Our response or resilience depends largely on the lives that we have lived and the positive experiences that might have buffered us from harm.

One definition of trauma that I like is "*anything that you have experienced that you did not have the resources or support to process in a healthy way*". When alone in the trauma, a difficult event or toxic stressor can become overwhelming and it has the potential to leave a long shadow with lingering effects – often presenting as an emotional response or behaviours better understood as 'survival strategies' designed to keep a person safe, or at least help them 'feel' safe.

Being trauma-informed is about understanding some of the fight, flight, freeze or fawn responses and hyper-alert to trauma triggers. In his 'Polyvagal Theory', Dr Stephen Porges describes these behaviours as involuntary and highly adaptive responses to feelings of threat that are triggered from a person's autonomic nervous system. The rude or reactive responses you might witness from a patient, observing them as shutdown or helpless, needy and demanding, faking good or catastrophising bad; these behaviours need to be better understood as survival strategies that are outside a person's conscious awareness or choosing, but likely help keep people safe. Consider the iceberg model and know that the behaviour being acted out is not the person; the behaviour is a symptom of what has gone on in his or her life and likely stems from an unmet need, frustration, fear, hurt or struggle.



Being trauma-informed is therefore understanding that we are all different individuals and that some of us need a different approach to care than others. It is about actively avoiding eliciting those responses in the people we work with and the patients we see. It's about understanding what constitutes for PCS (Positive Childhood Experiences); those activities, experiences and practices that help to mitigate or buffer the physiological and psychological effects of adversity and trauma. It is learning about Dr Bruce Perry's Neurosequential Model of the brain (NMT) and understanding what triggers those fear induced outbursts in our clients, from the bottom of the brain (the brainstem) up to the top (the cortical brain), and how we might work to mitigate them and help children regulate.



Know that trauma knows no sex, age, colour or tax bracket. We have all experienced trauma, either individually or through society. We are all paying the cost. As my colleague suggests, *"We don't leave trauma at home when we come to work".* As clinicians, we need to assume a trauma history is present in everyone, particularly indigenous tangata whenua who, through the research on epigenetics, may have experienced what is now understand as 'intergenerational trauma'. Like fossils in our genome, intergenerational or historical trauma is a unique form of trauma sometimes referred to as "*a soul wound*" that can get passed down from one generation to the next. We have begun to appreciate that as individuals, we are not slates from which our history can be rubbed away by a duster. We carry our experiences with us, both the good and the bad stuff. As the whakatauki states, "*Kia whakat omuri te haere whakamua"*; we walk forward into the future facing back. As Mark Wolynn writes in his book "It Didn't Start With You', family trauma shapes our health, who we are and how we communicate, and that we need to learn how to end the cycle and reclaim lives.

To be trauma-aware, we need to therefore take precautions in our approach with everyone (patients and colleagues alike), to decrease the likelihood of triggering a trauma response in both the 'us' and the 'them'; and some more than others.

According to Dr Kiri Prentice (Psychiatrist and Deputy Clinical Director at Māori Minds), practicing a Trauma-informed approach sits comfortably within a Tikanga-informed framework. Offering the qualities of safety, choice, collaboration, transparency, trustworthiness and empowerment are synonymous with the same qualities and essences of Māori matapono (values); kaitiakitanga (guardianship), wairuatanga (spirituality), manakitanga (hospitality), whakatipu tapau (uplifts tapu), whakapiki mauri (builds wellbeing) and the all-important quality of whanaungatanga (relationships). As Dr Bruce Perry from 'Child Trauma Academy' claims, "*It is people, not programmes, which change people".*

So, how might a trauma-informed approach look for you as medical practitioners?
Dr Sandra Bloom from 'The Sanctuary Institute' proposes a model or blueprint of change which, at its core, promotes safety and recovery from adversity through the active creation of a trauma-informed community. The components of her model enhance a practice where clinicians:

- Consider the possibility that trauma might be an underlying problem for every patient;
- Recognise the power of trust and mistrust as a major on-going issue;
- Understand that a history of violation will led to hypersensitivity about physical exams. So involve the patient in the appointment. Help them feel in control;
- As a physician, be honest and clear in explaining what you are doing and why;
- If you cannot understand why someone does or does not do something that seems to be common sense - be curious, enquire;
- Don't make assumptions about how a person has been affected by what seems like a traumatic event – ask about their story;
- In short, CARE about the person in front of you for all that they are, understanding and responding with kindness and respect.

And know that learning about someone's trauma history does not mean you have to fix it. Healing happens within relationships and just being heard and seen encourages growth and strength.

> "In this circle...we are trauma-informed. We connect before we correct. We stay curious, not furious. We understand behavior is communication. We believe in co-regulation, that kids regulate off the adults in their lives. We think can't - not won't. We empathize when someone is flipping their lid. We believe in restoration, not punishment. We believe that relationships buffer stress and build resilience. All of us need one another, always. Resilience means, we see you, we hear you, we are with you."

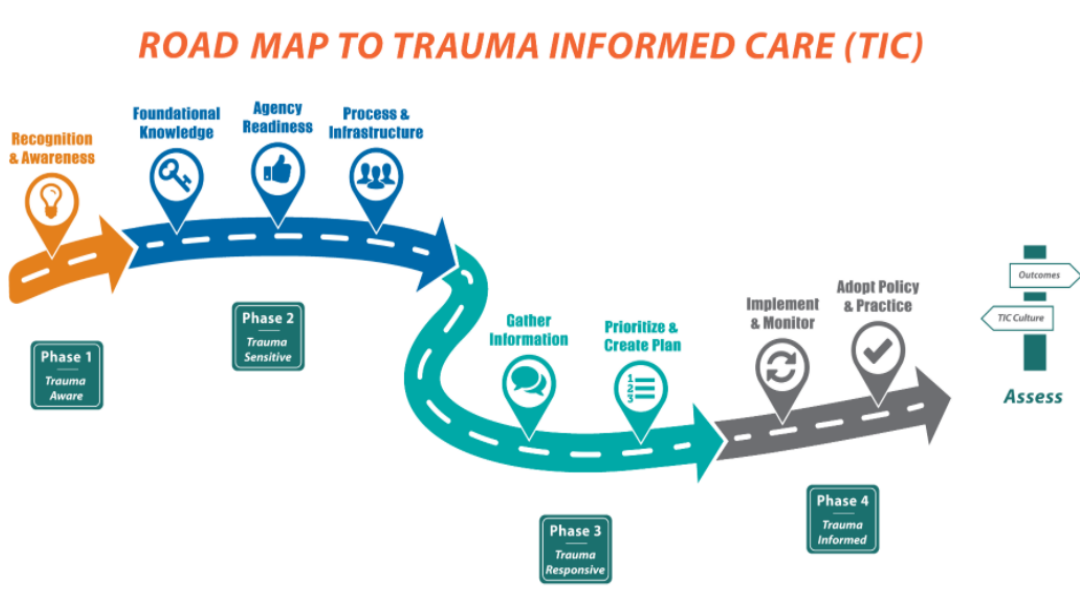
In more practical or operational terms, if someone has fallen over or needing to be seen after an assault, ask them how they are doing. Enquire if they are OK after the experience. Ask if they might need some help from you, and then respect the answer they give you. Enquire how you might best help them up off the ground or progress through an examination and

who they might want to be with them. Give them informed choices in every step of the process, and explain what you are doing before you do it. Offer reassurance as you do it and make sure you ask for feedback. And check that they were OK afterwards. Talk with them about ways that they might be able to avoid falling over again, get assaulted again, or ways that they could help keep themselves safe if there was ever a next time. And finally, if you promised anything, be sure you actually follow-through.

Yep, being trauma-informed is not rocket-science.
You may already be excelling in this approach, and if you are, well done.

Trauma-Informed Care is less about doing and more about being; being present and being sensitive. It is offering that paradigm of care; being available to listen, reflect back, and provide reassurance, emotional safety, comfort and respect. Because, sometimes what patients really need has nothing to do with the medicine you might prescribe. As Dr Glen Colquhorn, the poet and General Practitioner from the Kapiti Coast, suggests, "*it's people who are the medicine to people".*

Becoming trauma-informed is a journey. As Mandy Davis from 'Trauma Informed Oregon' (TIO) suggests, *"it is a marathon not a sprint*". So start your journey and consider the TIO road map. Begin by becoming trauma-aware then keep going. Know the direction you need to go, buckle up and enjoy the landscape; because your clients definitely will.



Debbie Watkin
Registered Psychologist
Te Puaruruhau, Starship Child Health
Te Whetu Ora
Te Toka Tumai, Auckland