Using a Model for Trauma-Informed Social Work Practice in the Provision of Relational Containment

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Learning Objectives

- Learn principles of a trauma-informed practice model of human-services delivery;
- Be informed about contemporary research findings on the prevalence of trauma in consumers of human services and the impact of chronic trauma on these consumers;
- Learn about the interference caused by trauma in the development of children's brains, interference that can have long lasting impact on a survivor’s behavior and stress response system;
- Learn about the impact on survivors of using a trauma-informed practice model versus a traditional practice model, with the former providing opportunities for strengthening the survivor’s stress-response system and the latter carrying a strong possibility of overwhelming a survivor’s stress-response system and of triggering further stress.

The potential implications of these studies for human services practitioners are profound. How would it change our communication with a client if we considered that the very act of his asking for help could trigger in him the same feelings and bodily sensations that he had when, as a little boy, he was repeatedly beaten when he asked for help? What are the costs of human services professionals’ lack of understanding that cumulative experiences of triggered memories of trauma automatically change the brains of trauma survivors and make them more emotionally reactive and less able to control behavior? What knowledge about repeated psychological trauma do we as policy makers, service providers, and educators want to invest in to be the most effective practitioners possible?

In the past decade, in response to statistics about the prevalence of trauma among human services recipients and the many questions these findings raised for them, leaders from different helping professions sought the input of trauma experts and survivors to better understand the experiences and needs of survivors of trauma. Conferences and interdisciplinary focus groups were created with goals of considering policy changes that would contribute to more effective services for survivors. 6

Dr. Ann Jennings is the trauma service system consultant for The Substance Abuse Mental Health Services Administration (SAMHSA) and has presented throughout the country about trauma-informed systems of care. In her article, “Behavioral Health Systems and Trauma-Specific Services,” prepared in 2004, she wrote:

It has become evident to a critical mass of mental health leaders in decision-making positions that:

- a majority of persons served in public mental health and substance abuse systems have experienced repeated trauma since childhood;
- they have been severely impacted by this trauma; ignoring and neglecting to address trauma has huge implications for use of services and costs incurred;
- evidence exists for effectiveness of trauma-based integrated treatment approaches and promising practice models designed for, and providing renewed hope of and recovery to, clients with complex trauma and severe and persistent mental health or addiction problems;
- many of these trauma-informed and trauma-specific models are...
Dr. Jennings has been a strong supporter of public service leadership across the country joining together to advocate for the adoption of trauma-informed policies in human service agencies.

Two of the most influential leaders among many to have invested in efforts to change policies to accommodate the needs of trauma survivors are psychologists Maxine Harris and Roger D. Fallot, colleagues at Community Connections, a mental health clinic in Washington DC. Dr. Harris is a co-founder and CEO of Clinical Services and Dr. Fallot is Director of Research and Evaluation at the clinic. Together they authored the book Using Trauma Theory to Design Service Systems, New Directions for Mental Health Services. Interestingly, Harris and Fallot did not set out to design a model of trauma-informed service delivery. They instead set out to identify changes that would need to happen at all levels in their treatment center if their guiding principles focused on efforts to avoid triggering, retraumatizing, or revictimizing survivors who came to their center. Their influential model of trauma-informed practice, which will be referred to often in this essay, was the ultimate product of their innovative brainstorming.

In a training document that she wrote Dr. Jennings summarizes the proposed principles and policies described in their book:

To address the treatment and support needs of survivors of trauma within the public service system requires a systemic approach characterized both by trauma-specific diagnostic and treatment services and a “trauma-informed” environment capable of sustaining these services and supporting the positive outcomes to clients who receive these services. The new system will be characterized by safety from physical harm and re-traumatization; an understanding of clients and their symptoms in the context of their life experiences and history, cultures, and their society; open and genuine collaboration between provider and consumer at all phases of the service delivery; an emphasis on skill building and organizing experience that forms the core of an individual’s identity rather than a single discrete event; and by a focus on what has happened to the person rather than what is wrong with the person. Without such a shift in the culture of an organization or service system, even the most “evidence based” treatment approaches may be compromised. (Saakvitne, 2000; Harris & Fallot, 2001).

“Trauma-informed” services are not specifically designed to treat symptoms or syndromes related to sexual or physical abuse or other trauma, but they are informed about, and sensitive to, trauma-related issues present in survivors. A “trauma-informed” system is one in which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that violence plays in the lives of people seeking mental health and addictions services (Harris & Fallot, 2001). A “trauma informed” system uses that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid inadvertent retraumatization and will facilitate consumer participation in treatment. It also requires, to the extent possible, closely knit collaborative relationships with other public sector service systems serving these clients.

The Massachusetts Executive Office of Health and Human Services has been an active participant in the national effort to promote the acceptance of a trauma-informed model of service, and last year it sponsored a conference for human-service agency leaders throughout Massachusetts with a goal of “identifying core elements of trauma-informed practice that should be standard across all agencies.” Harris and Fallot’s model played a prominent role in suggestions discussed at this conference.

There is perhaps no group of professionals so “informed” about the existence of psychological trauma in the histories of people they serve as are social workers. With a professional mission of “enhancing the well-being of all people…with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty,” and who are “victims of social injustice,” we can surely say that ours is a profession committed to people who have known trauma. Social workers should not be surprised, then, to learn that primary principles at the core of trauma-informed human services models are exactly those stated in our professional preamble and ethical principles: “respect for the dignity and worth of a person,” “investment in the empowerment of people who are vulnerable,” attention to “the central importance of human relationships,” and recognition of “clients rights to self-determination.”

What may be newer for some social workers to incorporate in their thinking are recent research findings on the impact of trauma on neurobiological development of children and on the brains of those who have known repeated trauma. Social workers will be interested to learn that this research also supports principles central to our profession in its confirmation that attachment relationships are essential for the developing brain to optimally mature and that strength-based communication stimulates neuronal growth in parts of clients’ brain essential for learning, regulating their emotions and behavior, and creating an autobiographical narrative about who they are. I believe that social workers have a lot to learn from these findings, which will both support and profoundly deepen what we already know.

**Objectives of This Essay**

This essay addresses the principles of a trauma-informed practice model of care and the enormous relevance this practice model has for social workers, other human services providers and for those who seek their services. It addresses the research- and evidence-based practice findings that have motivated leaders to promote this model and that serve as guides for many social workers. It explores the impact of differences in the thinking of some traditional practice models and a trauma-informed one. It assists readers in understanding why adopting a trauma-informed practice model is imperative, if social workers are going to be effective in their roles as clinicians, advocates, policy-makers, caseworkers, administrators, and educators in serving the needs of trauma survivors.

Central to an understanding of the relevance of a trauma-informed model of practice is the knowledge that repeated, overwhelming experiences of trauma automatically change the stress response system of a victim’s brain. Implied in the model
is an assumption that human service providers can facilitate positive changes in a trauma survivor’s brain, especially in the ways that survivors respond to stress. Looking first at normal development and then at development impacted by chronic trauma, the essay examines how early attachment relationships impact a person’s stress response system. It introduces the concept of relational containment and the potential roles social workers play in providing containing functions to their clients and to each other. It defines the diagnostic category of “complex post-traumatic stress” and some of the reasons that human services for those with complex post-traumatic stress need to be different than services found in many traditional practices.

The essay addresses the expectable presence of secondary traumatic stress in professionals exposed to violence and trauma and who work in systems that minimize or devalue indicators of secondary traumatic stress among their staff. It presents some of the challenges creating a trauma-informed practice model in an organization and the compelling reasons for embracing these challenges.

The Prevalence of Chronic Trauma In the Histories of Human Service Consumers

Trauma experts have been puzzled that, in spite of the statistics regarding the prevalence of trauma histories in human services consumers, it seems infrequent that case conferences and case records address the central role that a person’s complicated trauma history plays in his daily struggles or in the recommended service plan. Dr. Jennings, in a document prepared to help human services leaders implement plans to bring a trauma-informed model of practice to state agencies, expressed her concerns:

The experience of trauma can be extremely damaging and often has enormous costs. Unresolved, untreated trauma is central to the development of multiple, severe, and persistent health and mental health problems, substance abuse, criminal behavior, and social problems in our society, and should therefore be a key consideration for policy making in each of these fields. Addressing trauma must be central and pivotal to public health and human service policymaking including fiscal and regulatory decisions, service systems design and implementation, workforce development, and professional practice. Unless trauma is addressed, the damage to individuals and to society will continue.

The statistics that support these concerns are staggering. The Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services has had a huge role in funding research that has resulted in the development of statistics about trauma survivors who seek services from agencies. They have also been active in financing grants in support of agencies that develop evidence-based programs for survivors. At a conference on trauma-informed care in 2004, A. Kathryn Power, director of The Center for Mental Health Services within SAMHSA reported: “In the United States, a child is reported abused or neglected every 10 seconds. Up to 30 percent of girls and up to 20 percent of boys are sexually abused before they reach adulthood. Approximately 1.5 million adult women and 835 thousand men are raped and physically assaulted by an intimate partner each year. Roughly 4 to 6 percent of our elderly are abused, primarily by family members.”

Power went on to say: The effects of trauma spill over into many segments of our society.

Our streets and our shelters are filled with the victims of trauma. Seventy percent of women who are homeless were abused as children. Nearly 90 percent of women who are both homeless and have a mental illness experienced abuse both as children and adults.

Our jails and prisons are filled with the victims of trauma. Eighty percent of incarcerated women have been victims of physical and sexual abuse. The majority of murderers and sexual offenders, who tend to be male, have a history of childhood maltreatment.

Our hospitals and our clinics are filled with the victims of trauma. The majority of both men and women in substance abuse programs report childhood abuse or neglect. Each year, more than a half-million women injured by their intimate partners require medical treatment.

Our graveyards are filled with the victims of trauma. Each year, 2,000 children die from maltreatment; ninety percent are under the age of five.

Trauma is pervasive, it is damaging, and it is an extremely serious threat to our public health.

In a 2004 document “Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services,” prepared, again, by Ann Jennings for the National Technical Assistance Center for State Mental Health Planning (NTAC), National Association of State Mental Health Program Directors (NASMHPD), she and her colleagues wrote:

Individuals with histories of violence, abuse, and neglect from childhood onward make up the majority of clients served by public mental health and substance abuse service systems.

- 90% of public mental health clients have been exposed to (and most have actually experienced) multiple experiences of trauma (Goodman, Rosenburg et al., 1997; Mueser et al., 1998)
- 75% of women and men in substance abuse treatment report abuse and trauma histories (SAMHSA/CSAT, 2000)

Among youth in juvenile detention centers, the incidence of Post-Traumatic Stress Disorder is eight times that of youth the same age in the general population. The prevalence of self-reported exposure to traumatic experiences by youth in some juvenile detention centers is as much as 93%. Boys are more likely to report that they have witnessed violence, and girls are more likely to report that they have experienced violence.

In a report written in 2006, “Responding to Childhood Trauma: The Promise and Practice of Trauma-Informed Care,” Gordon R.
Hodas, MD, who is a statewide child psychiatric consultant with the Pennsylvania Office of Mental Health and Substance Abuse Services, reported the following:

82% of all adolescents and children in continuing care inpatient and intensive residential treatment programs in the state of Massachusetts were found to have histories of trauma as reflected by a point-in-time review of medical records. (LeBel J, Stromberg N, 2004)

Nearly 8 out of 10 female offenders with a mental illness report having been physically or sexually abused (Smith, 1998). Each year, between 3.5 and 10 million children witness the abuse of their mother. Up to half of these children are also abused themselves. (p. 72)

Dr. Hodas addresses the importance of considering not just the immediate but also the persistent effects of childhood trauma on a child, “including disruption of the normal developmental process—and longer-term outcomes on the child once grown up.” He offers additional statistics on the prevalence of trauma among human services recipients, the long-term effects of which we can imagine based on our understanding of trauma:

Up to 81% of men and women in psychiatric hospitals diagnosed with major mental illnesses have experienced physical and/or sexual abuse. Of note, 67% of these individuals experienced their abuse as children (NASMHPD/NTAC Report).

Dr. Hodas praises the significance of the longitudinal outcomes that the Adverse Child Experience (ACE) Study found, outcomes that confirmed what social workers know well from their experiences: the more risk factors a person has in her history, the more vulnerable that person is to being a victim of trauma during the remainder of her life.

SAMHSA’s Kathryn Power acknowledges, “No matter what its cause, trauma presents us with one over-riding concern. Trauma in our homes, our streets, and our communities has profound negative effects on our nation’s mental health and our capacity to respond.”

**Introduction of a Trauma Informed Model of Service System Delivery**

In their book *Using Trauma Theory to Design Service Systems*, Maxine Harris and Roger Fallot have outlined requirements they believe are important in creating a trauma-informed system of care, along with principles they believe are central to such a system. They join others who believe that a trauma-informed practice model should be adopted by all human service delivery systems, not just the agencies that specialize in trauma treatment. They differentiate between “trauma-informed” services and “trauma-specific” services. Trauma informed services are those that take into consideration the strong possibility that a vast majority of clients seeking their services have chronic trauma histories, and that adopt protective policies and practices to reflect this reality at all levels of service delivery. Trauma-specific services are those that provide services meant to address, reduce, or stabilize symptoms or behaviors that have been identified by both the provider and consumer as related to one’s traumatic past.

Harris and Fallot view the two most important features of any trauma-informed service delivery model to be its commitment to universal screening for trauma by well-trained staff and its expectation that all staff will be trained to understand the complicated impact of trauma on a survivor’s development, relationships, and behavior. Universal screening ensures that information critical for effective service delivery is gathered. It also ensures that a situation common to survivors is not repeated in which someone in power expects someone with less power to keep quiet about something that is extremely stressful in that person’s daily life. The model acknowledges the extreme care with which one needs to choose language, mannerisms, and expression of affect in screening for trauma so as to do everything possible not to trigger past, dysregulated traumatic memories.

Harris and Fallot believe that primary to an understanding of the impact of trauma is the understanding of the potential for repeated trauma to derail normal development. This is particularly the case when a child’s primary caretaker is the perpetrator of his/her trauma. The most devastating impact of repeated trauma is a person’s ultimate loss of a reliable sense that he can count on relationships for comfort and containment. With this absence of a reliable sense that there are containing relationships that can be counted on for support, a person experiences stress that is hard for him to regulate on his own.

If we as human services providers were to name a single set of struggles at the heart of a chronic trauma surviving client’s presenting difficulties, it might be that he struggles to regulate his stress; has difficulty finding relational help in regulating his stress; and has developed cumulative patterns of trying to regulate his stress on his own that, while sometimes effective in the short term, have been often ineffective and hurtful in the long term. A model of trauma-informed service delivery assumes that a human service system can create policies of service provision that result in recipients building or restoring a sense of reliability that relationships can be counted on for comfort and help. An exploration of normal development and ways development is intruded on by repeated trauma will help us appreciate the monumental importance of this reliability.

**The Evolution of Relational Containment in Normal Development**

A sense of containment is what a person feels when she feels secure, alert, safe, confident, hopeful. One feels contained when she can count on “being OK,” relatively relaxed and assured that she is able to effectively deal with what ever challenges she soon faces. We serve as sources of containment for others and others serve as sources of containment for us. A person feels contained as long as those she depends on as sources of containment for her are “OK.” We can each note what has happened to our sense of “OKness” and to our daily functioning when we have learned that someone we are close to is seriously ill or has died.
A person’s sense of containment is contingent on the quality and reliability of her attachment relationships.

To experience trauma is to experience an absolute loss of any sense of containment in a given point of time. To experience trauma repeatedly is to experience losses that carry more profound developmental implications. With an investment in helping a trauma survivor restore capacities to reliably experience a sense of containment, it is useful to consider how these containing capacities evolve over time in normal development.

### Containment & Early Attachment Relationships

Early in a baby’s life, his caretaker provides containing functions for him. These are functions that the baby will depend on for healthy growth and development. Among these functions are: comfort; structure and limit-setting; protection; tolerance of and responsiveness to the baby’s expressed feelings; intellectual and sensory stimulation; developmentally attuned communication in response to both the baby’s pleasure and his stress; barriers to stressful stimuli; and more. The baby comes to rely on these functions in order to feel a sense of containment, to feel calm, safe, alert, and secure that his needs will be responded to in ways that decrease his stress. When a baby has been reliably provided these containing responses he begins fairly early in his life the lifelong process of regulating his own stress just by anticipating the provision of these functions. For example, a young infant can feel relief from stress when he hears or sees his caretaker approaching or smells her prior to any comforting action she actually takes. The baby thus begins to internalize an association between the experience of stress and the anticipated presence of the caretaker to whom he feels attached. He associates the anticipation of the presence of a caretaker with an expected sense of comfort and containment. The capacity to hold onto memories of a state of relative comfort is a precursor to being able to regulate emotions for the rest of a baby’s life.

As he gets older, because he has partially internalized the secure sense that his caretakers will be there when he needs them, the young child is freer to invest energy in the world and other relationships, within which he practices his growing competence. He learns to find his own relative relief from stress just by thinking about his caretaker, or being reminded of him—“Daddy is coming back soon.” The child thus gradually supplies some of his own containing functions (comfort, tolerance of a little sadness that Daddy is not here, etc.), a process that in optimal development deepens in its containing effectiveness as the child gets older and as interpersonal exchanges take on more complex and profound meaning.

In optimal development, the young child’s patterns of seeking and receiving relief from stress through her important attachment relationships are patterns that mature and become refined. Experiences of security in attachment relationships gradually are able to be transferred to experiences with teachers, other relatives, siblings, peers, unseen heroes, lovers, partners, one’s own children, helping professionals, and others.

### Attachment and the Brain’s Stress Response System

The brain is equipped with a complex set of functions that make up a person’s stress response system. This system becomes active when it detects threat; it engages responses to the threat to ensure the person’s survival; and it becomes inactive again once the threat no longer exists. Ideally, when an infant experiences stress, a response is activated (he cries)—he soon experiences attuned responses from his caretaker (he is picked up, fed, helped to get to sleep, etc.) his stress is relieved, and he returns to a state of containment. A brain that has had repeated experiences of changing from a state of stress to a state of containment as a result of attuned attachment relationships becomes “hard wired” to make these same state shifts from stress to containment with much greater ease for the rest of the person’s life. In becoming “hard wired” the same set of neuronal connections and chemical responses in a person’s brain that are activated when stress is experienced and relieved, is likely to get activated again in similar circumstances of stress in the future. With this repetition a person’s experiences of stress become associated with anticipated experiences of containment and with an internalized, non-verbal sense of “I’m going to be OK.”

The opposite is also true. Brains that have had repeated experiences of changing from a state of stress without accompanying relational containment to a state of greater stress become “hard wired” to make these state shifts with much less ease for the rest of a person’s life. If stress is not relieved by containment offered in an outside relationship, the stress response system does not turn off, but remains on and moves beyond crying to greater efforts to get relief. Experiences of stress become associated with anticipated experiences of greater stress and a state of, “I’m not going to be OK.” Social workers know of clients’ patterns of problematic behaviors associated with efforts to deal with these states of stress followed by states of anticipated greater stress—clients who don’t show up, or who notably withdraw as you are talking with them, flee your office, or yell at you for something you have or have not said.

The paths of these behaviors are often associated with actions of fighting, fleeing and freezing, which the stress response system automatically activates when it perceives threat. These adaptive shifts from stress to defensive behaviors are not in the control of the person trying to survive, but are controlled by the automatic activation of his stress response system. A model of a trauma informed service delivery views all symptoms of a trauma survivor as having an origin in a defensive attempt to cope with stress that he was not equipped to cope with and that was not accompanied by relational containment.

### Containment and the Balance of Activity in the Left and Right Hemispheres of the Brain

In optimal development a baby is initially dependent on the functions of outside containing relationships to regulate his right-brain activated stress response system. Gradually it is
the maturity of his left-brain functions that helps him partially regulate his own stress. Structures and functions of the left brain are associated with the abilities to focus, reflect, plan, pay attention, use signals in other’s faces to guide behavior, learn, think logically and rationally, access learned verbal forms of language, encode and retrieve verbal memory, develop an autobiographical memory, and put the brakes on and control emotions. It is the left-brain that enables a person to place memories in the context of time, place, and ownership. We might consider the trauma survivors we know and the extent to which they can rely on the above abilities of their left-brains as they attempt to meet the challenges of everyday life. With the left-brain active, formal and informal learning can take place: Children and adults can keep exploring new ground and finding broader pockets of competence. With both sides of the brain active, they are able to integrate experiences: feel the emotional and sensory aspects of experience (with the right brain) and make logical sense of and attach understanding, thoughts, and language to experiences that include a context of time and place (with the left brain).

In their chapter, “Treating Dissociation” in the book, Treating Complex Traumatic Stress Disorders, Kathy Steele and Onno van der Hart address useful concepts in thinking about both normal development and development that is intruded on by chronic trauma. They write about two major categories of action systems that are basic to all mammals: those that guide functioning in daily life and those that, in response to high stress, guide defensive functioning. We will explore how a person’s chronic trauma impacts these action systems. “Daily life action systems include social engagement, attachment, caretaking, exploration, play, sexuality, and energy management.” Daily life action systems are associated with the activation of structures and functions of the left-brain, which again are associated with the abilities to focus, reflect, plan, pay attention, use signals in other’s faces to guide behavior, learn, develop, and access learned verbal forms of language, encode and retrieve verbal memory, develop an autobiographical memory of oneself, and put the breaks on and control emotions. With good enough relational containment these functions begin to mature early in life and increase in complexity, reliability, and effectiveness, as one gets older. These left-brain functions associated with one’s daily action systems can be activated only when a person is in a relative state of containment, when his stress response system is relatively inactive.

Defense action systems include several subsystems: attachment or separation cry; hyper-vigilance; flight; fight; tonic immobility (freeze); and flaccid immobility (collapse.) These defensive systems are activated automatically, outside a person’s control, when the person perceives threat. These actions are not chosen and when they are activated they are not in one’s conscious awareness. We notice that the first defense action in response to feeling stress and perceiving threat is the attachment cry, a primitive signal to the primary object of attachment that containment is needed. This is the action familiar to most of us in response to a high state of stress. If the stress system senses that the first action of defense will not lead to survival or relief of stress, it engages the next action system in line. For example, if relief from stress isn’t received as a result of a person’s crying, she enters a state of hyper-vigilance, for both, sensory details that might help her get what she needs, and for cues that relational containment might be able to be found. In the midst of extreme stress (and triggered traumatic stress), a person’s stress response system will bypass earlier actions and will immediately engage in fighting or fleeing if she thinks she can more likely survive by doing either. If helpless to escape danger by being active (fighting or fleeing), a person will try to survive by becoming inactive (by freezing and becoming immobile – a primitive action in hopes that an enemy will view an animal or person as dead and will cease attacking).

We can think of those trauma survivors, who when asked a question in an intake interview, criticized by a boss, or yelled at by their three year old, experience extreme levels of stress. Accompanying this stress there is not the internalized containment that enables them to deactivate their stress responses and engage their left-brain functions of limiting their emotions, reflecting on the meaning of the question or behavior, holding onto narrative memories of their strengths and competence, deciding on the best plan of action etc. With histories of limited relational containment; fragile capacities to contain themselves in moments of stress; and hard-wired neuronal connections of states in which stress is expected to be followed by more stress, these survivors, instead of listening and being reflective, lash out with a fight response of yelling, attacking or criticizing, or a flee response of, “I quit,” or “I’m leaving and not coming back”, or of emotionally withdrawing from family members and/or service providers.

Defense action systems are associated with brain structures and functions of the right brain. In response to threat, a person’s autonomic nervous system activates the stress-response system to engage in whatever action it perceives as necessary to survive the danger. From a trauma informed perspective it is critically important to understand that in the present moment a stress response activated defensive action (i.e. running in terror, or fighting to open the door) which is identical to the defensive action system during an original trauma, (i.e. running in terror in Iraq upon hearing the unexpected sound of a grenade, fighting to open the door after being thrown into and locked in a dark closet as a three year old) can be activated when any fragment of that original traumatic event is experienced or remembered in response to a current reminder of it (i.e. hearing the unexpected sound of a car backfiring while walking through one’s neighborhood months after she has returned home from the war, or having a person quickly close her front door when as a stranger to her, you, as a teenager, knock on her door to ask her a question.) These actions, provoked in the present by seemingly neutral stimuli in the eyes of anyone else, are for the trauma survivor “triggered reactions” to unintegrated traumatic memories. This essay will repeatedly address the frequent presence of these reactions for trauma survivors, their potential to make survivors feel retraumatized, and their impact on the survivor’s brain. It will highlight the service provider’s role in helping the survivor prevent triggered reactions, and in facilitating their regulation when they are experienced.
Daily life-action systems and defense action systems work in tandem—when one is active the other isn’t. Harris and Fallot’s investment in creating a model of service delivery that prevents trauma survivors from being triggered or retraumatized makes so much sense if their goals were to help survivors activate left brain functions that would increase their engagement of strength based daily action systems. As was mentioned in the description of the concept of containment, when a person is in high stress, the left-brain functions associated with effective daily life action systems are deactivated. The needs for containment of a baby and young child in normal development are in many ways parallel with the present needs of trauma survivors in creating and restoring capacities for containment.

To bring to life the issues being discussed here and to highlight the importance of understanding the role of relational containment in fostering maturity and trauma resolution, I would like to share two stories, one about my son and me, and another about another three year old child. I hope that they will assist the reader in appreciating the complexity of a person’s stress response system during and after a traumatic event and what is required not only to facilitate the deactivation of that system, but also the gradual reintegration of his balance of right/left brain functioning. In the story of Teddy and me, I want to highlight three processes:

1. The moment-to-moment process of a child in extreme stress during and immediately after a traumatic event, which is traumatic to him (right brain activity totally dominant; left brain activity inactive, shut off).

2. The progression of processes following the traumatic event, of a child in stress seeking relational containment, finding it, and using it to increasingly activate his own left brain functions to more freely engage in daily life actions and verbal dialogue with others. This entails a transitional period of time in which he remains vulnerable to right brain activated fragments of distorted thinking without context of time, place and ownership (right brain activity still dominant; left brain activity increasingly more active) and only gradually transforming the experience to one remembered with integrated memory.

3. A child’s ultimate transformation, using his own and others’ provision of relational containment, from being traumatically overwhelmed to creating=finding a coherent, integrated, autobiographical narrative of a scary event, with appropriate context of time, place and ownership. “Before my birthday this scary thing happened to me, and Mommy and me were really scared and we cried” (right brain remains active; left brain activity dominant).

I will invite you to compare Teddy’s process of trying to resolve his trauma with the process of another three year old trying to resolve his trauma.

My son Teddy and I were in the car stopped at a stoplight. Teddy was almost three years old. As I stopped the car, I vaguely noticed a small group of pedestrians and dogs in front and to my left of my car, waiting to cross the street in front of it. Teddy was in a car seat in the front seat, and, as we waited for the light to change, I turned my head toward him and away from the group of people crossing. In what must have been four or five seconds, I heard a sudden, unfamiliar, and monstrously loud sound and felt something for an instant at the back of my head. What is far more memorable is that I saw in Teddy’s face an expression of utter terror that I had never seen before as he focused on something behind me.

His eyes opened in horrendous fear and his mouth opened wide, as if to scream, but there was no sound. He lunged toward me and when he could not free himself from the car seat to get to me, he flailed his arms and legs in erratic, uncontrolled ways as he began to scream in an unfamiliar, high-pitched cry. His face changed to an expression of pleading to get him out of his seat. By the time I turned to see what was behind me, a woman had regained control of her two Great Danes, which had managed to jump up on our car and extend their heads into my open window as they barked and growled.

Teddy saw this entire happening; I didn’t. I immediately unstrapped Teddy from his seat, and, once free, he lunged toward me and hung onto me tightly as he continued to scream and cry and move his body as he hung onto me, sometimes in a seeming state of rage and sometimes in a seeming state of defeated sorrow. As I held him and talked to him, trying to offer him words for what he might have experienced, he gradually cried less. The more I talked, the more his stress decreased, until after a while he seemed calm enough to return to his car seat so that we could start home. During this time of being frightened and ultimately calmer, he said very little.

As we drove I kept talking and then hummed a song he liked. Teddy remained quiet. I registered exhaustion in him from his terrifying experience, but also he seemed to be thinking hard in silence. He seemed uninterested in replying to anything I was saying even though he clearly heard it. A couple of miles down the road, he turned to me and, with little expression of affect in his face or voice, spoke for the first time since the incident, “You know what, Mom?” “What?” I replied. He continued, “Sometimes I like to eat dogs right up with my big teeth.” “Whoa, Teddy,” I replied in an effort to just try to stay with him as he worked to feel more contained. “Yep,” he said and remained quiet again for another couple of miles. “Sometimes,” he spoke again, and after pausing for a couple of minutes, “Sometimes I can chew people’s heads off.” “Really?” I replied. “Yeah,” he said and added, “with my big teeth,” at which time he showed me his (little) teeth and a big, mean expression on his face.

That night he was more quiet than usual, and when he talked, he talked only about what seemed isolated fragments of his experience. Like those in the car coming home, they seemed to be disorganized perceptions born from a three-year-old mind in an effort to recall, with words, experiences that for him were still mainly wordless experiences.

The night of the incident, at bedtime, his Dad and I had to check several times for monsters with teeth under his bed, and
in the middle of the night he joined us in our bed. During the next several days he regressed to losing his temper far more easily than in the months prior to our experience, and he was clingier with me. His play was more aggressive, and he could be reduced to tears by tiny frustrations. We kept talking about what happened. I did most of the talking without asking him to respond. Increasingly the content of his sentences and play became less violent. As his Dad and I continued to reflect with him about what had happened and what we could imagine that was like for him, he became more engaged in dialogue with us about his memories, which in the beginning included more exaggerated recollections. “Yeah, it was scary, and I hate those dogs, especially the one with wet, shiny teeth, and big eyes, like this,” and he would mimic a scary face. “Mommy and me were very, very scared, and we both cried all day.” Within a couple of weeks our dialogue included a coherent story that Teddy could tell himself. “You know what?” he would ask people, “One day Mommy and me were in the car, and these two big dogs put their big heads right into Mommy’s car and barked and snarled at us… and Mommy and I were scared and I cried and Mommy made them go away.” I had no part in the dogs’ going away. This addition to his memory, which he created, is an example of a young child’s capacity to internally associate comfort with those who have provided it for him, and then, on his own, to use this internalization to regulate his own stress.

This story is a simple story, really, that many mothers could tell. The final story that Teddy, in his environment of privileges, developed about his earlier, single traumatic experience is likely not the story that many children and adults with chronic trauma without containment would be able to tell. Teddy’s story is strikingly different from the next one.

Around the time that this incident happened, I was a panelist at a conference at which a case was presented of an adult man, Mr. H, who had committed a hideous murder of an elderly neighbor. It was difficult to regulate my own containment as I listened to the details of his acts. They included that he had hit his victim. The details of his history were even harder for me to hear. In keeping with a trauma-informed model of practice, to reduce your stress by helping you anticipate that you will experience stress, I want to let you know that the description of Mr. H’s experiences that I will share will be brief, but difficult to read. Mr. H’s early developmental history included details of his mother’s frustration with him as a three-year-old for not being toilet trained. She would curse at him, rub his soiled underwear in his face, and lock him in a closet for long periods of time. He was removed from her care at the age of five and thereafter “cared for” in multiple foster homes, residential treatment centers, hospitalizations, juvenile detention centers, and court systems, while receiving years of counseling, protective services, case-management services, rehabilitative services, probation services, and psychotherapy before committing the murder that led to his imprisonment.

I invite us to consider Teddy’s experience of trauma as a three year old and the progression of steps he took on his journey from his traumatic event to his responses, to the event, to his adaptive use of resources and memories available to him in search of containment, to the solutions he found, and to the ultimate impact of his traumatic experience on his life. I then invite you to consider Mr. H’s experience of trauma as a three year old and the progression of steps he took on his journey from his one detailed traumatic event that we know of, to his responses to the event, to his adaptive use of resources and memories available to him in search of containment, to the solutions he found, and to the ultimate impact of his traumatic experience on his life. Using this progression of steps and hypothesizing about our clients’ experiences moving through them are useful tools for us to use in understanding the impact of trauma on their lives.

We see in these stories the essential role of containment within an attachment relationship in a person’s ability to transform his initial terror to an integrated sense of solution, including being able to remember the details of the events. In resolution one moves from a state in which his defensive stress-response system is in extremely high activity and dominant; through states in which access to his daily life action systems increase, but are fragile; and finally to a state in which his daily life action systems are reengaged as dominant action systems. Teddy could be observed to move repeatedly through cycles of relational containment, itemized below, to find increasingly more coherent thinking. In these slow repetitions, each time Teddy sought relational containment and received it, he seemed to be able to access more of his left-brain functions to make sense of his experiences, which in turn, enabled him to find greater capacity to engage in more meaningful and containing dialogue with me. With each cycle of seeking containment, we observe his solutions moving from being totally right brain dominated (when he was clinging to me and crying); to his being more verbal and interactive, but still with right-brain dominated sharing of only fragments of memory with primitive emotions, and little time, place, and ownership of actions and feelings perspective (I [in the present] like to eat dogs with my big teeth [which implies that I am certainly not scared]); and finally to the solution of realistic narrative of integrated memory that included accurate memories with appropriate time, place and ownership of appropriate actions and feelings perspectives (This event happened to Mommy and me and we were scared.) Having a coherent narrative of his integrated memories allowed him to recall the events with a tolerance of the feelings accompanying them.

<table>
<thead>
<tr>
<th>Cycle of Stress Accompanied by Containing Responses that Enable Healthy Development (SACRED)</th>
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<tbody>
<tr>
<td>A child/ adult:</td>
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<tr>
<td>1. Experiences normal and inevitable stresses of daily life challenges</td>
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<tr>
<td>2. Seeks relational containment</td>
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<td>3. Experiences relational containment that helps stress response system be minimally active</td>
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<td>4. Experiences integrated balance of left and right brain functions</td>
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<td>5. Uses available relational containment and integrated left and...</td>
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NASW-MA FOCUS CE Course: Using a Model for Trauma-Informed Social Work Practice in the Provision of Relational Containment
right brain functions to activate daily action systems, which mature and contribute to the deepening internalization of more sophisticated skills in seeking and finding containment and in thinking, learning and processing.

6. With increased deepening of relational and internalized containment skills, sense of security and competence grows. Increased security and confidence to explore new territory, increased engagement in new attachment relationships, increased discoveries of success, frustration, and problem resolution seeking.

7. Experiences inevitable stress (back to beginning)

We can only speculate about the cycles, through which Mr. H repeatedly moved, which were very different than Teddy’s. With Mr. H and with many of our clients, the moments, hours and days that they moved through cycles in attempts to resolve traumatic responses to unspeakable events with minimal relational containment available to them and increased stress or compromised defenses that they found are hard for us to imagine, but worth the effort so that we can better understand their current needs for containment. Some survivors have been given labels for the culmination of their efforts, without relational containment, to find solutions to chronic experiences of trauma. They are killers, perpetrators of abuse, cutters, substance abusers, screamers, liars, gang members, manipulators, addicts... The are “borderlines,” conduct disordered, oppositional-defiant, hyperactive, hypervigilant, unresponsive, over reactive, lazy, bipolar, depressed, anxious, and dissociated.

The behaviors that result in these labels are adaptive products of repeated cycles of seeking containment in response to stress and, in not getting it, learning to contain themselves without the provision of left-brain functions, since overactive stress responses have resulted in their left brains being frequently deactivated. The left-brain functions needed to put the brakes on the stress response system have not been able to mature. The available sources of containment are limited and in response to extreme stress, survivors’ efforts to seek relief to current and triggered memories of trauma entail defense actions that move quickly to fighting, fleeing, and freezing, again with limited left-brain accompanying functions to limit those actions. Without a cohesive narrative or integrated memories of traumatic events, Mr. H was likely left with only right-brain emotional and somatic fragments of memory that could become terrifying (i.e. fragments of sensory and emotional memories in that closet) because they signal that retraumatization will follow. This fear sets in motion automatic stress response activated behaviors that rid a person of the threat of retraumatization, even if a the result is losing their kids to DCF, murdering person, and ensuring they will be in prison for the rest of their lives.

Understanding a person’s movement through these cycles in her attempted resolution of trauma with and without relational containment helps us appreciate the role of relational attunement and neurobiological regulation in any service delivery system, on which trauma survivors depend. Differentiating some of the components of a person’s experiences of trauma, particularly the impact of chronic trauma will help us understand the importance of a trauma informed system responsive to those presenting with cumulative trauma.

Understanding Trauma

Challenges of Defining Trauma

Earlier we identified two elements, which Harris and Fallot identify as essential in adopting a model of trauma informed service delivery: universal screening for the presence of trauma in a person’s history and the training of all staff about the potential impact of trauma on survivor-consumers, who seek their services. Defining “the impact of trauma” on a survivor is a challenging, but critical task.

It is common for professionals and laypersons to use the word trauma very loosely and for the definition of trauma to vary widely. We are accustomed to talking about “being traumatized” by events that were merely very upsetting. It is not uncommon to read in a case record or hear in a description that goals for a trauma survivor are for him to “talk about his trauma so that he can resolve it,” “get over it,” “feel it,” “mourn it,” or “get beyond his defenses so that he can deal with it.” Mental health professionals say things like: “Program goals will be to help them work through their trauma,” and “Most people experience trauma at different times in their lives and most get over it, so why should clients with a trauma history need a different model of treatment? A lot of people are depressed. Should we create a model of practice for depressed people too?” or “He acts that way because he was traumatized as a child” or “This child was traumatized; was sexually abused by his step father from the age of four to the age of twelve, and then it stopped.”

How would we respond to the comments and questions above from a trauma-informed perspective? What is the “it” of trauma that a person, once he has experienced “it,” needs to “resolve, get over, feel, mourn, get beyond, work though, or deal with?” What makes experiences of trauma so developmentally costly to some people and, for others, a catalyst for effectively “doing good in the world?” Indeed many persons whose symptoms can be intrusive on their development would benefit from an entire agency or group of agencies gearing their policies and practices to his needs, so why a model for those with symptoms related to only histories of chronic trauma? When a child is traumatized from the ages of four to twelve, at twelve and a half is “it,” the “trauma,” then over? Does it no longer exist? Why do leaders, who are invested in a model of trauma-informed services delivery, view the adoption of it as so imperative for human services caseworkers, advocates, administrators, agency leaders, community organizers, clinicians, supervisors, and program planners, and other office staff members?

One response to this latter question is provided by Dr. Ann Jennings in her 2004 speech, “Models for Developing Trauma-Informed Systems and Trauma-Specific Services”: “Until recently, we believed the effects of trauma were mostly psychological, but new brain imaging techniques show that...
childhood abuse can cause permanent damage to the neural structure and functioning of the developing brain. This damage can seriously impair a person’s lifetime ability to cope with additional trauma and even with life’s daily stresses.”

When people use the word trauma, they are usually trying to describe one of four aspects of a traumatic experience: an event, responses to that event, traumatic memory, and the impact of traumatic responses on the future ways a person views himself, his relationships, and the world.

**Traumatic Event**

A traumatic event is usually an objectively definable happening, the immediate experience of which is so sudden, frightening, and/or unfamiliar that it cannot be integrated with a person’s current developmental capacities and thus overwhelms the person’s stress-response system. It is one’s subjective experience of a happening that makes it traumatic or not. We know that an event that leads to traumatic responses in one person may not lead to traumatic responses in another, the most notable example of this being that younger children do not have the capacities to integrate experiences that mature persons have. Teddy as an adolescent would have likely responded very differently to those dogs that jumped on the car. Young children’s stress-response systems are more vulnerable to being overwhelmed when, given the immature functions and structure of their brains, events are beyond what they can integrate.

Dr. Judith Herman, pioneer clinician in the trauma field and author of the book *Trauma and Recovery*, wrote about traumatic events being overwhelming to a person’s ordinary internal systems of care, systems that they count on “to give them a sense of control, connection, and meaning. Traumatic events confront human beings with the extremities of helplessness and terror and evoke the responses of catastrophe.” Authors Dr. John Briere and Dr. Catherine Scott, in their book *Principles of Trauma Therapy*, wrote, “An event is traumatic if it is extremely upsetting and at least temporarily overwhelms the individual’s internal resources.” Lenore Terr, author of *Too Scared to Cry*, says, “Traumatic events are external but quickly become incorporated into the mind.” She distinguishes between Type 1 single event traumatic events—a traumatic accident, a natural disaster, dogs with big teeth jumping up on a car, a terrorist attack, a single episode of abuse or assault, witnessing violence—and Type 2 complex or repetitive trauma, such as ongoing abuse, domestic violence, community violence, war, or genocide, being repeatedly physically abused and locked in a closet as a three year old.”

Models of trauma-informed services delivery have been created primarily in response to the awareness of the impact on persons, who have known Type 2 chronic trauma. The trauma of being the object or witness to repeated and prolonged trauma makes it impossible to identify a “traumatic event or events.” We will address this further when we define Complex Post-Traumatic-Stress.

Laura S. Brown, author of the chapter “Cultural Competence,” in Ford and Courtois’ book *Treating Complex Trauma*, talks of author and independent scholar Dr. Maria Root’s concept of “insidious trauma,” in which the traumatic events are “dominant group member acts of ‘everyday’ cultural bias operating as a continuous stream of small traumatizations that may appear to have no effect but that can have a cumulative effect when the latest, equally seemingly small event occurs. Exacerbation of symptoms may not require news of a hate crime against members of one’s own group; it can occur in response to the latest exposure to everyday bias, discrimination, or invisibility, which is itself a form of psychic violence.” This is a profoundly important category of traumatic event for human service providers and survivors/consumers to understand, particularly with regard to the impact of the insidious trauma of everyday experiences of racism.

It is likely that many persons who seek social work services are survivors of some form of insidious trauma related to being victims of repeated “small acts” of “dominant others.” It is interesting to consider the possibility that some people have experienced insidious trauma just because of their long-term experiences as being dependent on human services agencies. For a survivor of chronic trauma there can be heightened reactivity to the stresses that can accompany this dependence. One of my favorite stories as a social worker is of supervising a very competent colleague in an adolescent residential treatment center, where her efforts to attract parents to a support group, an outing group, and a supper group had each failed. I invited the two of us to brainstorm about what would be possibly energizing for these mothers, who had likely been so disempowered in their lifetimes. I joked that she could have a pizza group with a babysitter available for mothers interested in sharing stories about negative experiences with social workers in their lifetime. She did just that, and mothers came and bonded as they competed to share a story to top the last one told about insidious trauma they had endured as disempowered objects of “dominant group member acts of ‘everyday’ cultural bias.” I’m not sure that the method has promise as a powerful, trauma-informed, evidence based practice method, but the stories shared by group members turned from negative experiences with human service providers to moving and empowering experiences of providing and receiving containment from each other and their leader around the multitude of challenges that they faced in trying to find solutions for their trauma. None of them, prior to the group, associated daily challenges they had in regulating their behaviors and relationships with their substantial histories of repeated trauma.

**Responses to Traumatic Events: When the Stress Response System Won’t Turn Off**

The ultimate impact of trauma is related to the responses of stress that persons experience following traumatic events and the extent to which their stress is responded to and reduced, as a result of experiences of relational containment.

As previously addressed, a normal stress-response system has its own mechanisms of perceiving threat or danger, activating a
survival response, and then releasing chemicals that help turn that stress response off once the danger has passed. An active stress response system includes physiological experiences of increased heart rate and accelerated breathing, sweating, increase in body temperature, and blood flowing away from the skin to muscles to better help a person to mobilize his body to act in order to survive. One’s stress response system operates outside her control. My young son used to take great pleasure in hiding next to a doorway and watching my stress response system in action after he would jump out and say, “Boo!!” as I walked through. Typically I would scream in fear, jump, admonish him for his sadism, and continue on my way. My heart would be racing, but I could be assured that by the time I got to the washing machine or wherever I was going, my heart would be back to normal. As a ten-year-old he questioned my intelligence in asking, “Mom, why do you keep jumping in fear? You know that always it’s only me!” I didn’t have the answers or brain acknowledgement that it was “only him” in the millisecond in which he jumped out at me. I have also had more experiences than I care to admit of being surprised to find myself in the path of an oncoming car or bus, at which time I experience instant terror and jump back to the curbing. My heart is pounding and my muscles, which propelled me out of danger two seconds prior, are limp. I catch my breath and by the time I’m on the other side, my heart rate is normal. One’s stress response system doesn’t distinguish between a car appearing out of nowhere in your direction and the sudden “boo” of a young boy taking pleasure in disempowering his mother. These responses to sudden potential threat are not within a person’s control.

Stress responses are controlled by one’s autonomic nervous system. Responses to extreme stress can take the direction of hyperarousal, in which case a person responds by engaging with greater levels of activity (anxious, yelling, fighting, fleeing) or they can take the direction of hypoarousal, in which case the person responds by disengaging and becoming inactive (depressed, numb, freezing, becoming immobile or collapsing).

In traumatic stress, the stress-response system is activated to such high degrees by structures and functions in a person’s right brain, that the survivor is vulnerable to being unable to shut off his stress response even when the danger has passed. A stress response that cannot be turned off leaves survivors in potential states of intense hypervigilance, panic, numbness, terror, and vulnerable to an urgency to stop these feelings through adaptive engagement of behaviors that bring them immediate relief. As has been mentioned previously, once one has had a traumatic response to an event, whereby she has had overwhelming stress and dysregulating fight, flight, or freeze behaviors activated by the right brain’s stress response system, she is vulnerable to having a triggered traumatic response. In this response a small reminder from a past original traumatic event, can activate the stress response system again in the present, and the body experiences the same extreme stress that it did during the original danger. We recall that this is a “a triggered reaction to stress.”

Human service providers using a trauma informed model of service delivery recognize how intrusive these responses can be on daily action systems. They are trained and supported to do everything possible to avoid communication and behavior that is likely to trigger threatening experiences in survivors.

As a baby matures and throughout her lifetime, she relies increasingly on the maturation of her left-brain structures and functions to help her turn off her right-brain-activated stress. As stated previously in maturity, these left brain structures need to be active in order for a person to focus, plan, learn, encode and retrieve verbal memory, and put the brakes on and control intense emotions. In a state of right-brain-activated high stress, there is an automatic decrease of activity in left-brain-activated parts of a person’s brain. In a state of right-brain-activated traumatic stress, the left-brain functions are deactivated all together, so that defense action systems can be engaged with a minimum of interference. We can imagine what would happen to a person who finds herself in the pathway of an oncoming car if her left brain functions became activated to reflectively think about what she should do as she notices the car careening toward her or if of if she took a second as the car was moving toward her to remember what she had done the last time she was in this situation! With her left -brain functions deactivated, her right brain stress response system can help her automatically flee in the seconds she has to survive being hit. These defense actions in acute stress are key to our survival, but can be difficult if they trigger a veteran to leap into the bushes on his college campus for cover in response to his hearing a firecracker.

### Traumatic Memory

Persons have at least two forms of memory that are relied on to recall previous experiences. We are accustomed to thinking of our explicit memory as our only memory system, but another memory system, our implicit memory, is always in operation as well. Rothschild defines explicit memory as comprised of facts, concepts and ideas. “When a person thinks consciously about something and describes it with words- either aloud or in her head- she is using explicit memory.” Explicit memory requires language. Explicit memory is critical for all left-brain functioning. A person’s capacities to plan, reflect, formulate judgments, and recall strengths that served her previously are all dependent on explicit memory. Rothschild continues, “ Explicit memory is not just facts, however; it also involves remembering operations that require thought and step-by-step narration… it is explicit memory that enables the telling of the story of one’s life, narrating events, putting experiences into words, constructing a chronology, extracting a meaning. Explicit memory of a traumatic (or any) event involves being able to recall and recount the event in a cohesive narrative.”

Explicit memory matures at around two and a half years of age. It is mediated by the left-brain hippocampus. Explicit memory – a left brain activated system - is suppressed by the right-brain stress response system during the extreme stress of a traumatic event and during a triggered flashback of a fragmented traumatic memory.

The second form of memory that is important for human services providers to understand, especially regarding experiences of trauma survivors, is implicit memory. Rothschild states,
“implicit memory bypasses language. It involves procedures and internal states … Implicit memory enables a person to do something without thinking about it.”28 Implicit memory entails remembering events or responses only with one’s feelings and bodily sensations (without words).29 They are experienced as fragments of thought, feeling, or sensation without context of time and place. The capacity to form and retrieve implicit memory is mature at birth, so memory of the first two and a half years of one’s life is primarily through implicit memory.

Unintegrated (without access to explicit memory) implicit memory is what is laid down during traumatic stress and what is experienced in the automatic reaction of being triggered. A traumatic “flashback” is a hallmark of implicit memory in post-traumatic-stress. In a traumatic flashback for example, a person who was raped, might later experience bodily sensations of that rape, without any explicit recall or understanding of what the sensations could be related to. Implicit memory is mediated by the amygdala in the right brain, the same brain structure that is in charge of the stress response system.

In health, a person has access to integrated memory of experiences, which includes both forms of memory when recalling a traumatic event. Teddy, immediately after the dogs jumped onto the car, had only his somatic and emotional implicit memories with which to process the event. Gradually explicit memory with words and narration were more available to him, until he was finally able to create the integrated memory that included both accurate and tolerable feelings and narrative of what happened with proper place and time.

Resolution of a traumatic response to an overwhelming event does not entail the reexperiencing of it, but rather the ability to develop a cohesive narrative with integrated memory of the traumatic events. A person can then allow herself tolerable emotions and somatic experiences while recalling the time and place of a traumatic event as she creates an autobiographical narrative of an extremely difficult event, which she knows and feels is solidly in her past. Without relational containment and time, chronic traumatic memories are difficult to integrate. Without integration a survivor remains vulnerable to right-brain triggered implicit “memories” comprised of somatic sensations and feelings that have no narrative explanation and which are experienced as happening now, even though they happened in the past.

Practitioners using a trauma informed practice model appreciate that patterns of behavior, like substance abuse, domestic violence, and self-mutilation are often chosen by survivors, who feel helpless to get relief from triggered implicit traumatic memories through other means. These practitioners refer these survivors to trauma specialists, who understand that their role is to collaboratively educate the survivor about what is happening to him and teach him grounding techniques so that he can be empowered to anticipate and regulate his reactions before he is triggered. These providers understand that some “problematic behaviors” may serve the containing function of protecting a person from unintegrated implicit traumatic memories, and that the motivation and tolerance to change them cannot be expected until a person can replace them with healthier regulating behaviors. They understand that for a survivor, reexperiencing implicit trauma responses in a somatically and emotionally overwhelmed state serves no healing purpose. In fact, it can increase the likelihood that a person will be retraumatized by these experiences.

**The Impact of Trauma**

The impact of trauma on a person greatly varies depending on: 1. variables specific to the victim, (e.g., the victim’s age or the extent of previous exposure to traumatic events) 2. characteristics of the stressor (e.g., whether it is present once or repeatedly in a person’s life and whether it is impersonal, as in a hurricane, or interpersonal, as with sexual abuse by one’s mother) and 3. how those around the victim respond after her experiences of the traumatic stressor (e.g., whether a child is punished for telling about a traumatic experience and left to cry herself to sleep or is provided the interpersonal and, if needed, professional support immediately and over time, support necessary for her to integrate her experiences).30

The responses of those who relate to the victim following a traumatic event are critically important to consider in our assessment of trauma. An important resilience factor for trauma victims is the immediate opportunity to engage in dialogue about the traumatic event and their memories of and responses to it within an empathic attachment relationship. What is so important about a person’s attachment relationships is their potential capacity to facilitate containment that allows a person to deactivate his stress response system and activate left brain integrative functions that help to regulate the stress response system. This was made clear in the processes with which Teddy engaged following his traumatic responses. The more verbal and interactive with me he was, the more integrated his memories became.

A trauma informed practice model is responsive to the cumulative impact on trauma survivors of repeated exposure to events, which separately and together, are traumatically overwhelming. With repeated trauma, the specific events that were overwhelming are less focused on and less able to be recalled in a survivor’s narrative memory. A survivor, who has been in seven foster homes and two residential placement facilities since he was removed from his mother at the age of five, rarely actively remembers the sexual abuse documented when he was four. The survivor adapts to the absence of attuned relational responses of comfort and dialogue in response to his traumatic experiences by adaptively seeking comfort and containment on his own. He achieves this with whatever external resources are available to him and with the limited internal developmental capacities that his age and maturity level afford him.

A tragic impact of traumatic responses that are repeatedly unaccompanied by comfort and containment is that they lead to dysregulation of thinking, feeling, and making meaning of events, which contribute to a survivor’s negative views of himself, others, and the world. Daniel Siegel talks of the
brain being an expectation machine. Dr. Siegel reminds us that a person seeks explanations for why things are happening and he finds them, by himself or with the help of others. An extremely costly impact of trauma is that a survivor creates an explanation for what is happening to him that includes confusing and self-denigrating explanations for their struggles and/or, for the defensive patterns of behavior that they have adaptively created to protect themselves over time. These explanations can significantly alter all parts of his life — i.e. how worthy of support he believes he is, how smart he feels, how much power he believes he has in changing what is uncomfortable for him, etc. Again, the recognition of this cycle as having begun as an adaptive effort to cope with traumatic responses and memories is what distinguishes a model of trauma informed service delivery from traditional models of practice. Pearlman and Courtois in their article “The Treatment of Complex Trauma,” speak of the importance of a provider’s empathy for the “mistrust, emotional lability, and relational instability” of adult survivors. Pearlman and Courtois continue by stating that the provider “cannot assume that chronically traumatized individuals have the experience base to form stable relationships, or the ability to maintain relational continuity even when others (including the therapist) are reliable, consistent, and trustworthy.”

The Impact of Chronic Trauma: Complex Post-Traumatic Stress

A person who has witnessed or been the object of only a single experience of trauma is rare among trauma survivors who seek help from human services systems. While many survivors whom social workers see may be motivated to seek services in response to a recent single incident, these persons have frequently also known experiences of trauma earlier in their lives, which influence the intensity of their responses to the recent single event. Some of the most significant recent research on the impact of trauma has been research on the impact on attachment, development, and lifelong behavior patterns in survivors of chronic trauma.

Many leaders in the field of trauma have openly expressed concern that the Diagnostic and Statistical Manual of Mental Health Disorders does not have a diagnostic category that adequately describes the experiences of a majority of chronic trauma survivors. Judith Herman first proposed the diagnostic concept of Complex Post-Traumatic Stress (CPTS).

Great effort has been invested in getting the American Psychiatric Association to adopt a new diagnostic category with descriptions relevant to common patterns of behavior of people with chronic trauma histories. Symptoms of Post-Traumatic Stress Disorder tend to be specifically related to a traumatic event and specific responses to memories of that event. Symptoms of Complex PTS are not related to one or a set of events but to products of cumulative responses to repeated and prolonged trauma.

Complex psychological trauma is defined by Julian Ford and Christine Courtois in their book Treating Complex Traumatic Stress Disorders as “resulting from exposure to severe stressors that: are repetitive or prolonged; involve harm or abandonment by caregivers or other ostensibly responsible adults; occur at developmentally vulnerable times in the victim’s life such as early childhood or adolescence when critical periods of brain development are rapidly occurring or being consolidated.

Complex post-traumatic stress can include problems with dissociation, emotional and behavioral dysregulation, and somatic distress that for the survivor are not connected to memory of trauma. Many survivors who experience complex traumatic stress have little memory of any traumatic events in their early lives.

Recently I listened to the case description of a 17-year-old adolescent now locked up in a juvenile detention facility for the eighth time.

Joe was born to a 16-year-old woman who had few sources of support and her own history of chronic abuse. As a toddler Joe would be in the front seat of cars while his Mom would be in the back seat engaged in sex for money. He became involved with Department of Children and Families at a young age and ran from several foster homes in search of his Mom. When he was 13 he watched his uncle get murdered in the streets. He is now gang involved. One day before his most recent lock up, while his social worker drove him to yet another foster home, the social worker asked Joe how many times he had taken this drive to a new foster home, to which Joe replied, “more than I can count on both hands and then some,” as he fiddled with his plastic garbage bag filled with his clothes, toiletries, and a poetry book.

Joe is an excellent candidate for a diagnosis of Complex Post-Traumatic-Stress-Disorder if such diagnosis existed in the Diagnostic and Statistical Manual of Mental Health Disorders. He surely has a trauma history, but a potential provider could not tie his present struggles to any one or group of traumatic events in his life. While Joe’s case records attests to many single heart-breaking events to which Joe had overwhelming traumatic responses, it is the cumulative impact of these responses and the resulting dysregulation to which Joe has been made vulnerable, which create challenges for him in his day-to-day efforts to live outside the walls of the juvenile detention system. It is this cumulative impact of responses, which policy makers, supervisors, teachers, advocates, and other human services providers must take into consideration in their plans for service delivery. What does Joe need from his foster family, his teachers, his tutor, his boss, his human services providers in order to feel contained? What external provision of relational containment will enable him to begin a path of being able to find internal capacities to contain himself? Who of his providers will understand his behaviors as a series of adaptations that began before he could talk? What dialogue would need to happen before his providers, other that his present social worker, might discover that he has a poetry book in the single bag of things that he owns in the world?

While more difficult to hypothesize, we can ask ourselves what series of containing functions should Mr. H have been able to rely on, not just in the care of his mother, but in the care of all of the systems on which he relied after his removal from his
Mom’s care? What might have been put in place that would have helped him move through the similar cycle of containment and integration and higher levels of processing of his experiences that Teddy moved through? What models of service delivery might have promoted his finding a different solution to his likely repeated, three year old aloneness, terror, and rage felt in that dark closet, than the one that culminated in his biting and killing his elderly neighbor?

We have already discussed one of the most debilitating Complex Post-Traumatic experiences for survivors of chronic trauma - their vulnerability to being “triggered” by reminders of past trauma. Policy makers and other providers are challenged to create services that incorporate an understanding that, when triggered, the survivor has no conscious control over their defensive action systems of fighting, fleeing and freezing, no context for understanding his sensations and feelings, and no words to describe them.

Some survivors, once they are calmer, can describe these moments of triggered fear and their defensive action-system-driven flight, fight, freeze reactions to them. Common descriptions include, “I just had to get out of there. I felt that if I had stayed there one more second, I would have died; pieces of me would have just have started to unravel”; “I knew I had to cut myself, and if I couldn’t find a knife, I’d come apart. It was the only thing that would make the feelings go away. As soon as I found the razor blade, I knew that I was going to be OK”; “I can’t explain why I didn’t try to protect her. Once I heard her scream, my body just froze. I watched the whole thing, but I couldn’t move”; “I can’t describe it, man, it was like if I could just hit somebody, I knew that the shit rising inside there would go away.” We can imagine that Joe had many experiences of being overwhelmed without being contained, and his current vulnerability to being triggered in response to fragments of memories of those experiences. It would be interesting to inquire about what triggered memories might have preceded the fight and flight crimes, which Joe and many others with similar trauma histories committed and which landed them in a locked facility.

Many survivors’ behaviors that get labeled as serious problems— their impulsiveness, aggressive behavior, refusal to talk, withdrawal, depression, panic, sexual acting out, screaming, crying, raging, blaming, drinking, shooting up, stealing, beating, abusing, reenacting, neglecting, molesting, threatening, running away, and resistant behaviors—begin when they are triggered by the smallest things in the present and quickly become disregulated and thrown into traumatic states without any sense of containment. They adapt by containing themselves by themselves as best they can with familiar defensive actions. In these defensive states they are vulnerable to repeating patterns of behavior that are costly to them.

Among the most costly of defensive actions associated with repeated severe, chronic traumatic stress is the defense of dissociation. Dissociation implies a splitting of awareness of events or experiences. As discussed previously, dissociation is often a response that follows being triggered by traumatic memories. Babette Rothschild is a social worker that has written extensively about trauma, particularly a person’s somatic responses to trauma. She explains, “The mind separates elements of an experience to reduce the impact of an overwhelming incident.” She discusses psychologist Peter Levine’s model of dissociation known as SIBAM. SIBAM is an acronym for elements of experience: sensation, image, behavior, affect, and meaning. During dissociation one or more of these elements can be dissociated. A dissociative defense allows a person to escape events that are overwhelming. A common description of dissociation is of what can happen during experiences of sexual abuse when a victim dissociates from her experiences of being abused by viewing herself as watching another person being abused. Richard Lowenstein has written extensively about dissociative disorders and calls dissociation “the mind’s attempt to flee when flight is not possible.”

A person’s capacity to dissociate elements of experience that are unbearable for her is an extremely adaptive defense. What becomes problematic is that, with repeated dissociation, a person’s mind is vulnerable to perceiving present reminders of the earlier unbearable experience as a signal that dissociation needs to be activated to protect her again from feeling overwhelmed. The activation of this defense, as described earlier, is outside of one’s control and can be very intrusive to normal functioning. Author Joanne Twombly is a social worker that teaches internationally on the treatment of dissociative disorder. She warns that a reliable indicator of the presence of dissociative defenses in a person is patterned and extremely dysregulated behaviors, especially activated in prospective attachment relationships, which despite years of attempts to get help with, do not change.

Trauma-informed models of practice advocate that all staff be given basic information about communicating with a person who may be in a dissociative state and recommend dissociation-specific training for those in positions of helping survivors integrate their dissociative experiences. Without a practice model that incorporates an understanding of this complicated protective defense, primitive dissociative defenses and accompanying destructive and self-destructive behaviors can get unleashed that increase the likelihood that dissociative defenses will be used again when traumatic stress is triggered.

### The Impact of Secondary Traumatic Stress

Human service practitioners at all levels, who witness or learn about traumatic events of others, and who are direct objects of violence and abuse at the hands of some of their dysregulated clients, do not escape the parallel, automatic, repeated experiences that are activated by overwhelmed stress response systems. Responses can include cumulative changes in somatic, cognitive, emotional, behavioral, and relational experiences that frequently have significant impact on a provider’s sense of self, her relationships with others, and her view of her work and world.

The potential impact of repeated exposure to trauma on the service provider’s increasingly active stress response system
and the implications of resulting decreased activity of left-brain functions have already been discussed. The National Traumatic Stress Network describes the potential impact of secondary traumatic stress on professionals:

The impact of secondary traumatic stress can be the same as the impact of stress experienced by the direct victim of trauma events. Experiences might include increased fatigue or illness, social withdrawal, reduced productivity, feelings of hopelessness, despair, nightmares, feelings or re-experiencing of the event, having unwanted thoughts or images of traumatic events, anxiety, excess vigilance, avoidance of people or activities, or persistent anger and sadness. The effects of secondary traumatic stress may also include changes in how the individual experiences himself and others, such as changes in feelings of safety, increased cynicism, and disconnection from coworkers and loved ones. In the workplace secondary traumatic stress has been associated with higher rates of physical illness, greater absenteeism, higher turnover, and lower morale and productivity. People may also experience difficulties in their personal or professional relationships. They may have difficulty sleeping and eating, and may experience anxiety in relationships with family members or colleagues.

We have identified the greater likelihood of integration and resolution of their trauma experiences for those survivors who experience relational containment immediately following experiences of being traumatically overwhelmed. The same is true for providers. A significant factor in the quality, intensity, and duration of the impact of secondary traumatic stress on providers is the nature of personal and organizational responses to the presence among providers of secondary traumatic stress. For the past few years I have had the privilege of working with Massachusetts Department of Children and Family social workers, who have attested to the containment and empowerment that is the product of the support and confirmation they receive from some colleagues in response to the challenges they daily face and the to the secondary traumatic stress that is an inevitable part of their daily roles. As with any traumatic stress response, secondary traumatic stress responses can be helped to decrease and to become integrated into a coherent narrative when they are accepted as normal and recognized for the unique meaning they have for the provider. Collaborative and containing dialogue between a provider, colleagues, administrators and significant others can free her to have access to her left brain functioning and to return to what she creatively chooses to focus on, rather than what her stress response system automatically reduces her to attend to in the absence of relational containment.

A source of stress for many human services providers can be less the everyday exposure to the trauma of survivors they are committed to serving than to the limited relational containment they experience in the frequent hierarchical, and non-collaborative atmospheres of their work places. A model of trauma informed service delivery includes collaborative decision making at all levels. In the same way that it sets a goal for every interaction between a provider and survivor to result in a survivor’s experience of empowerment, it sets the same goal for interactions between a provider and his colleagues, no matter what their role in the organization. Many descriptions of survivors in case records refer to traumatic history of a person without addressing the complex relationships between the meanings of overwhelming events in a survivor’s past and events and current struggles the survivor is facing. These records rarely address some of the trauma survivors have experienced in the care of human service providers and institutions. A parallel process operates in terms of attention often being given to provider’s secondary traumatic stress without recognizing that agency policy and hierarchical communication practices also contribute to the provider’s stress. The principles inherent in a model of trauma informed practice is extraordinary for the containment they ensure providers as well as survivors. The potential impact on human service administrators, their staffs, and the survivors who depend on them, of adopting a trauma informed model of practice has monumental implications for the reduction in secondary traumatic stress and the increase of integrated experiences of competence that providers would experience.

A Model of Systemic Provision of Relational Containment

It is interesting to consider how many social workers might identify themselves as victims of secondary traumatic stress. How many might say that they have had repeated experiences of insidious trauma at having been a member of a group of professionals who at the very least have witnessed challenges faced by many people, whose needs have been ignored if not trivialized by a majority of people and politicians in this country for at least the last decade, and for many, much longer.

I began this article talking about social work principles and the ways in which a trauma- informed model of practice incorporated the most powerful principles that we identify as central to the values of our profession. I find those values - the importance of starting where the client uniquely is, respecting the dignity and worth of every individual, believing that all people deserve a just and generous environment in which to thrive along with their parents and children -still very powerful and containing. These values have been impressively captured in Harris and Fallot’s description of their model of trauma- informed human service systems. Even more exciting is that the practices that they encourage support assumptions and hypotheses that are products of a decade of research findings that we have come to understand about attachment, trauma, the brain, and behavior.

The baby thrives and develops integrated capacities to both seek and find containment in attachment relationships and in finding these, the baby is freer and more equipped to activate both his left and right brain functions so that he grows and gains comfort in learning to explore. The more contained he is, the deeper are his capacities to find and provide containment and the more sophisticated is his learning and his capacities to engage in daily action systems that are gratifying to him.

What are our own sources of containment as social workers and what are our containment needs? In what environments do we as social workers best thrive and grow? What do we internalize
each day in our work environments that leaves us feeling empowered? What would free us to most effectively access the highest skills our left brains would foster?

What do trauma survivors need from us that will make it most likely that they will feel contained, that they will gain increasingly integrated experiences and memories that might allow them to relax their stress response systems so that their left brains capacities can more frequently be activated? What complexities make it so hard for us to create environments that we know would best allow us to provide containment for the trauma survivors that seek our services?

I believe that Harris and Fallot answer some of these questions in their promotion of their model of trauma-informed practice. I invite you to consider the experiences of our clients, our own experiences, and those of our colleagues as we consider the potential impact of working in a system that adopts some of the values communicated within a trauma-informed model of practice. I invite us to consider what would happen to the stress response systems, the neurobiological integration, the narratives of trauma histories, the left brain activated strengths, the containment sought and found in attachment relationships of survivors, colleagues, and our own experiences if some of the following practices, quoted from Harris and Fallot’s book, were consistently used in all human service and government agencies.

In a trauma-informed approach, the emphasis is on understanding the whole individual and appreciating the context in which that person is living her life. This approach focuses on the individual and away from some particular and limited aspect of her functioning. Trauma-related symptoms arise as attempts to cope with intolerable circumstances. Survivors are seen as collaborators and as having wisdom and knowledge to bring to the process of working together. The emphasis is on increasing one’s sense of competence to understand a survivor’s behaviors not on symptom management. Services in a trauma-informed approach are strength-based. Ultimately the goal of services is to prevent problematic behavior in the future or at the very least to devise a plan on how to deal with crises when they arise. The goal of a trauma informed service system is to return a sense of control and autonomy to the consumer survivor. A trauma-informed system holds the underlying belief that if consumers learned to understand and ultimately to control their responses then they will need less if any help from service providers. Accordingly the emphasis is on skill building and acquisition.

This latter statement addresses the ideas explored throughout this essay. We have identified the culmination of a person’s cumulative experiences of being overwhelmed in response to traumatic events without accompanying containment. As providers we have opportunities to intercede in trauma survivors’ spiraling cycle of seeking containment and not finding it, making alternative efforts to relieve stress, which result in dysregulated feelings, thinking and behaviors. The goal of trauma-informed service systems to return a sense of control and autonomy to the survivor is a powerful statement about this model’s responsiveness to the brains of trauma survivors and to their needs for relational containment. The idea of the importance of a provider being always collaborative in his communication with both survivors and colleagues is beyond impressive in its understanding of the power of containment that accompanies collaboration. Overall, we can say that a model of trauma informed service systems proposes a systemic provision of relational containment for providers and consumers of human service agencies that adopt such a model.

We can try to imagine how any of the lives of survivors we serve might be different today had their parents been consumers of services in agencies that operated from a trauma informed perspective. What impact would it have had on Mr. H had the multitude of “caretakers” he had after he was removed from his mother been given the support of trauma-informed practice? What power are we willing to exert, as Joe enters yet another foster placement, to promote change in the many service delivery systems that he and others will depend on for containment, so that they are sensitive to the impact of trauma in Joe and his peers’ lives? What are the costs of not meeting the challenges of transforming our service delivery systems to those that practice with trauma informed principles? Whose responsibility is it to keep Joe from joining Mr. H. in a prison cell?

ENDNOTES

1, 2 Ann Jennings op.cit.
4, 5 Ibid
6 “In their own words: Trauma survivors and professionals they trust tell what hurts, what helps, and what is needed for trauma services,” Maine Trauma Advisory Groups Report 1997, www.theannainstitute.org/TOW.pdf
7 Jennings, op.cit
8-10 Ibid
12 Ibid
13 Siegel, D. (1999), The Developing Mind: How relationships and the brain interact to shape who we are, New York: Guilford Press; van der Kolk, et al., 1996
15 Ibid
18 Felitti et al., 1998, Centers for Disease Control and Prevention, 2005
19 Hodas, op. cit
20 Harris and Fallot, op. cit. g f
21-22 Power op. cit
23 Ibid
26 Courtois and Ford, op. cit., p. 181
27 Babette Rothschild, MSW The Body Remembers; The Psychophysiology of Trauma and Trauma Treatment, 2000, W.W. Norton Publishers, NY, NY, p. 28
28 Ibid p. 29
29 Ibid. p. 30
33-34 Ibid. Pearlman and Courtois, p. 454
36 Rothschild op. cit
39 Harris and Fallot, op.cit
1. In the United States a child is reported abused or neglected every…
   a. 10 seconds
   b. 60 seconds
   c. 4 minutes
   d. 2 1/2 hours
2. The model of trauma informed practice created by Harris and Fallot evolved from their creation of practice principles that focused on efforts to prevent triggering, retraumatizing, revictimizing survivors who came to their mental health center.
   a. true
   b. false
3. When a caretaker has reliably provided her baby with containing responses in his young life, that baby begins the long process of …
   a. regulating his own stress
   b. becoming too dependent on his caretaker
   c. negotiating sadness about separation
4. Left-brain functions associated with a person’s daily action systems can be activated only when her defense action systems are relatively inactive.
   a. true
   b. false
5. A trauma survivor engaging in the defense of dissociation may be trying to…
   a. escape events that are overwhelming
   b. flee events with his mind when flight is not possible
   c. split his awareness of events or experiences
   d. all of the above
6. Goals of Harris and Fallot’s trauma informed service system include…
   a. to return a sense of control and autonomy to the consumer survivor.
   b. to help consumers learn to control their stress responses
   c. devise a plan to help survivors anticipate future crises
   d. all of the above
7. Complex Post Traumatic Stress is defined as resulting from exposure to severe stressors that…
   a. are repetitive or prolonged
   b. involve harm or abandonment by caregivers or other ostensibly responsible adults
   c. occur at developmentally vulnerable times in the victim’s life
   d. all of the above
8. Among youth in juvenile detention centers, the incidence of Post-Traumatic Stress Disorder is _______ that of youth the same age in the general population.
   a. 2 times
   b. 3 times
   c. 6 times
   d. 8 times
9. The most devastating impact of repeated trauma is a person’s ultimate loss of a reliable sense that he can count on relationships for comfort and containment.
   a. true
   b. false
10. Insidious trauma can occur…
    a. in response to one’s latest exposure to everyday bias, discrimination or invisibility
    b. in response to dominant group member acts of “everyday” cultural bias
    c. as a form of psychic violence
    d. all of the above
11. A normal stress response system of a person’s brain has its own means of…
    a. perceiving threat or danger
    b. activating a survival response to a perceived threat or danger
    c. turning the survival response off once the threat or danger has passed
    d. all of the above
12. Trauma can be extremely damaging. Until recently, it was believed that the effects of trauma were mostly psychological, but new brain imaging techniques show that childhood abuse can cause permanent neurobiological damage to the structure and functioning of the developing brain.
   a. true
   b. false

13. In working with survivors who have histories of repeated abuse it is important for providers to have empathy for their…
   a. common a mistrust of others
   b. emotional lability
   c. relational instability
   d. all of the above
   e. none of the above

14. Complex Post-Traumatic Stress can include problems with dissociation; emotional and behavioral regulation; and somatic distress that for the survivor are not connected to memories of specific traumatic events.
   a. true
   b. false

15. Implicit memory is experienced…
   a. as only somatic sensations or emotions, and with no words
   b. without context of time or place
   c. in the automatic experience of being triggered
   d. all of the above

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Please indicate whether the following learning objectives were achieved...

A. Learn principles of a trauma-informed practice model of human-services delivery
   Achieved in full  5  4  3  2  1  Not Achieved

B. Be informed about contemporary research findings on the prevalence of trauma in consumers of human services and the impact of chronic trauma on these consumers
   Achieved in full  5  4  3  2  1  Not Achieved

C. Learn about the interference caused by trauma in the development of children’s brains, interference that can have long lasting impact on a survivor’s behavior and stress response system
   Achieved in full  5  4  3  2  1  Not Achieved

D. Learn about the impact on trauma survivors of using a trauma-informed practice model versus a traditional practice model, with the former providing opportunities for strengthening the survivor’s stress-response system and the latter carrying a strong possibility of overwhelming a survivor’s stress-response system and of triggering further stress.
   Achieved in full  5  4  3  2  1  Not Achieved

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