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FOUNDATIONS OF TRAUMA-INFORMED CARE:

AN INTRODUCTORY PRIMER

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Foundations of Trauma-Informed Care: An Introductory Primer

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About LeadingAge Maryland

LeadingAge Maryland is a community of more than 120 not-for-profit organizations and a wide range of collaborators united to shape the future of aging in Maryland. Our mission is to expand the world of possibilities for aging through advocacy, education, innovation and collaboration. LeadingAge Maryland is a state affiliate of the national organization LeadingAge. Resilience for All Ages is an initiative of LeadingAge Maryland dedicated to equipping individuals and organizations to become more trauma-informed and to advance trauma-informed work with older adults. Learn more at www.leadingagemaryland.org.

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Purpose of this Primer

Because work drawing on an understanding of trauma and of trauma-informed approaches is in relatively early stages of adoption among professionals working with older adults, this primer has been developed to provide these foundations to senior-level leaders of nursing home communities and to equip them to lead this work with both clinical and non-clinical staff. Requirements related to trauma-informed care are a part of Phase 3 of the implementation schedule for Mega-Rule changes. These requirements go into effect on November 28, 2019.

By participating in the Foundations of Trauma-Informed Care learning community, CEOs, administrators and other key senior staff members will build their understanding of the core research, definitions of terms and approaches that undergird the effective adoption of trauma-informed approaches to care. With this foundation in place, participants will be well-positioned to undertake the action steps necessary to comply with Phase 3 requirements, and in so doing, to create the conditions for better serving residents with trauma histories. Additional sets of resources, training and support for implementing trauma-informed care will be made available in the months to come.

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PREFACE

Background and Context

In September 2016 the Center for Medicare and Medicaid Services issued a set of changes to the requirements for nursing home communities that participate in Medicare and Medicaid programs. Sometimes referred to as the Mega-Rule update, these changes to the Requirements of Participation are the most comprehensive issued in the past twenty-five years.

According to CMS, "the policies in this final rule are targeted at reducing unnecessary hospital readmissions and infections, improving the quality of care, and strengthening safety measures for residents in these facilities."[1] The policies in the Mega-Rule update are being implemented through a three-phase process.

Among the many changes finalized in this rule are policies designed to strengthen the provision of person-centered care to residents.[2] Now in wide use across services for older Americans, person-centered care takes a holistic approach to meeting the needs of each individual resident, and considers psychosocial and spiritual aspects of well-being in addition to physical health. While the term "person-centered" mirrors CMS language, many nursing home leaders aspire to what might better be described as person-*directed* services and supports, characterized by a recognition of residents' rights to care that is shaped to meet their preferences and goals to the greatest extent possible.

In order to provide this kind of care to all residents, nursing home communities must be equipped to understand and work with the circumstances, needs and wishes of people who bring with them a wide variety of backgrounds and lived experiences. Accordingly, the new Requirements of Participation include an emphasis on providing services that are culturally competent — reflecting cultural awareness and humility — and that are sensitive and responsive to the special needs of residents who have experienced trauma.

The inclusion of a focus on trauma-informed care in the Mega-Rule update reflects increasing recognition across multiple health and human services disciplines that the experience of trauma is widespread across the population and has significant long term consequences for health and well-being. This recognition has led to the development of approaches for addressing the impact of trauma, some of them involving trauma-*specific* treatment, others involving creating conditions that are *sensitive* to the impact of trauma and to avoiding re-traumatization.

While significant research and practice work has been underway on trauma-informed approaches over the course of the past thirty years, within disciplines serving older people this body of work is still in early stages of widespread adaptation and adoption. Many of the policy changes included in the Mega-Rule update are layered on to a significant base of prior experience and expertise in long term care — however, work on trauma-informed care represents a relatively new discipline for most clinical and non-clinical staff in nursing home settings.

OUR UNDERSTANDING OF TRAUMA: HISTORICAL CONTEXT

Work around trauma and its impact has its genesis in treatment approaches. In other words, organizations first came to understand trauma — its nature, its impact and manifestations — in attempts to find ways to mitigate its harmful effects through treatment. The earliest and most extensive work on trauma outside a military context has been undertaken in organizations serving children and youth. The lifelong impact of childhood trauma has come to be well-understood across that field, and treatment methods are in use, and continue to be developed, in behavioral health and other clinical health settings as well as in social services and human services organizations serving children, youth and families more broadly.

The second domain where trauma has been closely examined, and treatment approaches tried, is work with combat veterans, many of whom manifest some degree of what was called PTSD and now is sometimes simply called post-traumatic stress.[3] Some of the earliest references to the impact of wartime trauma on soldiers date back to the Civil War and subsequently to World War I, when the condition was referred to as shell shock, and later, combat or battle fatigue. These terms encompass both the trauma of witnessing a particularly horrific shooting, explosion or other violence on the battlefield — sometimes called 'single incident trauma' — and the cumulative impact of multiple wartime experiences.

Single incident trauma, which is now also understood to include other non-wartime traumatic experiences like sexual or physical assault, is treated somewhat differently than what is called developmental or complex trauma — trauma that occurs and persists over a long period of time, such as childhood abuse, neglect or other deprivation. More recently, work on trauma has extended beyond children, youth, members of the military and veterans to include adults dealing with complex mental health issues, often rooted in earlier trauma — for example, adults experiencing chronic homelessness.

One of the milestones in this field dates to 1995, when a landmark study was published that demonstrated the close connection between childhood abuse, neglect, maltreatment and household dysfunction and adult health outcomes — outcomes that encompass not only physical but also emotional and social health. This study, commonly referred to as ACEs (Adverse Childhood Experiences study),[4] established that adverse experiences in childhood are common, and the number of these experiences correlates to a wide array of negative health outcomes, from diabetes and cancer to teen pregnancy, involvement with criminal justice and unemployment. The study has been repeated and the results replicated many times in the U.S. and internationally.

As the work of understanding, measuring and treating trauma in children advanced in the late 1990s through the early 2000s, organizations doing this work came to realize that an approach that was informed by an understanding of trauma involved not just treatment itself but also the environment in which the treatment was offered. ▶▶▶

▶▶▶ *Historical Context Continued.* In other words, creating a climate where individuals felt safe and supported in tackling their trauma histories and working toward health required more than skilled clinicians. It required a setting where an understanding of trauma was shared by all staff, and where the way the organization functioned was consistent with avoiding the creation of new trauma or triggering past trauma — a setting with a safe holding environment for clients as well as a safe, non-traumatic environment for staff. This approach was pioneered in the most intensive residential settings, notably by Dr. Sandra Bloom, founder of the Sanctuary Institute and author of *Creating Sanctuary: Toward the Evolution of Sane Societies* (first published in 1997), *Destroying Sanctuary: The Crisis in Human Service Delivery Systems* (2011), and *Restoring Sanctuary: A New Operating System for Trauma-Informed Systems of Care* (2013).

While work on PTSD in veterans extends back into the 1980s, much of the progress in that arena has occurred in the 2000s. In 2014, a major milestone was reached with the publication of a toolkit offering a roadmap for organizations serving veterans in general and homeless veterans in particular.[5] The toolkit detailed the process for becoming trauma-informed at the organizational level.

The field of aging services has come to the recognition and acknowledgement of the impact of trauma in recent years, with a small but growing number of publications and presentations emerging in 2013. These early efforts include some preliminary suggestions for becoming trauma-informed at the organizational level, but the majority of the focus has been on treatment. Work on traumatic stress in older adults is rooted in efforts to serve elderly Holocaust survivors.[6] In 2000 a scholarly article by two physicians at Tel Aviv University Hospital was published examining lifelong PTSD in aging Holocaust survivors. Around 2012, articles began to appear in the mainstream press chronicling the issues that older Holocaust survivors with PTSD were facing. Work around this same time was emerging within the field of services to aging veterans experiencing PTSD. Finally, the field of aging services has begun to address methods for treating older people who have experienced abuse as children. The journey to becoming a trauma-informed organization serving older people is in its earliest stages; it is also noteworthy that many settings in which older Americans receive care are not primarily behavioral health-focused, and so offer very limited or no treatment specifically for post-traumatic stress.

While children and youth, veterans and people experiencing homelessness are often served by organizations that are providing them mental health treatment, this is much less commonly the case with older adults. Accordingly, the work of creating trauma-informed aging services providers, including nursing home communities, must factor in the reality that staff members are less likely to have significant behavioral health expertise. Additionally, emphasis needs to be placed on creating a safe therapeutic environment for those residents who are receiving behavioral health services and also on creating an organizational environment for all residents that neither re-traumatizes older people with trauma histories nor creates new traumas.[7] It will also be important to focus on ensuring that all services, supports and care offered — including all medical care, enrichment and socialization services — factor in the reality that some residents will respond differently because of trauma histories, and will benefit from having those offerings provided in trauma-informed ways.

PREVALENCE AND IMPACT OF TRAUMA

While Americans once considered trauma to be a relatively infrequent occurrence, most research finds that a majority of us — somewhere between 55% and 90% by some measures — have experienced at least one traumatic event.[8] The ACEs study found that almost two thirds of respondents reported at least one adverse childhood experience. Other potentially traumatic experiences include experiencing or witnessing domestic and sexual violence, natural disasters, car, train and airplane crashes, combat, becoming a refugee, homelessness, medical trauma, violent crime, bias and discrimination, hate crimes and hate speech. In 2015, there were over 6 million motor vehicle accidents reported the United States; that same year over 1.2 million violent crimes took place. Natural disasters impact over 1 million Americans per year.

A potentially traumatic event, then, is any powerful event that affects your daily life. While not all of us will experience these events as traumatic, the reality that these kinds of events can be traumatizing is essential to bear in mind, given the impact that traumatic stress has on human health and well-being.

> "A majority of us — somewhere between 55% and 90% by some measures — have experienced trauma.[10]

Stress vs. Traumatic Stress

All human beings react to some external stimuli with a stress response. When startled by a loud noise or in the wake of a driver who cuts us off in traffic, or when one too many life pressures hits us, the human stress response makes our heart beat faster and we may feel a bit physically tense. While low levels of stress aren't harmful and the response passes relatively quickly, this same stress response plays a role when we experience truly overwhelming levels of what's called toxic or traumatic stress.

Traumatic stress refers to "the emotional, cognitive, behavioral and psychological experiences of individuals who are exposed to, or who witness, events that overwhelm their coping and problem solving abilities."[9] In other words, a trauma, which produces traumatic stress, occurs when our coping mechanisms are overwhelmed by outside events. With traumatic stress, the normal human stress response goes into overdrive and we experience it in a variety of ways ranging from the physical (muscle tension, headache, fatigue) to the emotional (irritability, depression, anxiety, alienation, hypervigilance, fight-flight-freeze responses) to the cognitive (disjointed thinking, worrying, impaired judgment, impulsivity, nightmares and other sleep disturbances and an exaggerated startle response). Humans also respond to stress behaviorally, by consuming substances like alcohol, eating more or less, being more or less sexually active.

OLDER PEOPLE AND TRAUMA

Over the course of their lives, many older people have experienced one or more of the potentially traumatic events and experiences described above — and the impact of that earlier trauma does not disappear with age. Of course older people are subject to these events in the present as well as the past, and so may have more recent or current traumas of these kinds with which to contend.

Older people also experience traumas related to the aging process itself, including the loss of loved ones, of their own capacities (physical and mental), of roles and identity and of their home, as well as the increased dependence on caregivers. Experiences of neglect and of elder abuse are also important to consider.

> "Behaviors can easily be misunderstood and diagnosed as dementia, psychosis, oppositional or willfully difficult conduct.

Manifestations of Traumatic Stress and the Risk of Misdiagnosis

Because people who have a trauma history may especially, if triggered, show signs of confused or disjointed thinking, irritability, impulsivity and a fight-flight-freeze response, their behaviors can easily be misunderstood and diagnosed as dementia, psychosis, oppositional or willfully difficult conduct. Older people with histories of abuse are also often misdiagnosed with personality disorders, including borderline, narcissistic and antisocial personality disorder, and as bipolar.[11] There is also evidence that hoarding behavior is more often found in individuals who have experiences of trauma, including neglect or physical or sexual abuse.

Reluctance to Talk about Past Trauma

It is important to bear in mind that older adults may be less likely than others to report histories of trauma. According to Joan Cook, Ph.D., associate professor of psychiatry at the Yale School of Medicine,

> *One issue in working with this current cohort of older (65 and above) adults is their potential denial or minimization of reporting of trauma and related symptoms. For some individuals in this current cohort, their traumas may have preceded the 1980 introduction of post-traumatic stress disorder (PTSD) into the official diagnostic classification. Thus they may associate more stigma or blame themselves for having experienced such event and/or having subsequent symptoms.* [12]

Without a sensitivity to the potential role of traumatic experiences on current behavior, older residents are at risk for the inappropriate use of antipsychotic medication and medications and other treatments for Alzheimer's disease and other cognitive disorders. They are also vulnerable to being labeled as difficult by staff members who may respond with disapproval and corrections that exacerbate the resident's sense of threat rather than creating a sense of safety. Staff members practicing the principles of trauma-informed care not only reduce the risk to residents, but also reduce the risk of harm to themselves and the organization.

DEFINING KEY TERMS

As part of the process of developing and refining the 2016 Final Rule, CMS elicited and responded to comments and questions and published these in the Federal Register. In responding to specific questions concerning definitions and guidance on trauma-informed care, CMS pointed nursing home leaders to the principles set forth in a 2014 SAMHSA resource entitled *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*,[13] saying that "the interpretive guidelines and the resource noted previously [SAMHSA publication] will provide further information regarding culturally-competent and trauma-informed care."

Accordingly, while there are many definitions of key terms offered throughout the literature on trauma, traumatic stress and trauma-informed care, those offered in this toolkit are largely based on, or drawn directly from, the SAMHSA resource on which CMS has relied.

TRAUMA

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

The Three E's of Trauma

The Three E's of Trauma are **event(s)**, **experience** of event(s) and **effect**.

EVENTS — can include actual or extreme threat of harm, or severe, life-threatening neglect for a child. Events can occur once or repeatedly over time.

EXPERIENCE — how the individual experiences an event helps determine if it is a traumatic event.

Factors include:

- How an individual assigns meaning to the event
- How the individual is disrupted physically and psychologically by the event
- The individual's experience of powerlessness over the traumatic event, which can trigger feelings of humiliation, shame, guilt, betrayal and/or silencing, isolation, shattering of trust, and fear of reaching out for help
- Cultural beliefs (e.g. about the role of women), availability of social supports, and age and developmental stage of the individual at the time of the event

EFFECT — adverse effects can occur immediately or after a delay, and can have a range of duration. Individuals may not recognize the connection between traumatic events and their effects.

Adverse effects include:

- Inability to cope with normal stresses of daily living
- Inability to trust and benefit from relationships
- Cognitive difficulties — memory, attention, thinking, self-regulation, controlling the expression of emotions
- Hypervigilance / hyperarousal, numbing, avoidance

TRAUMA-INFORMED

A program, organization or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths to recovery, recognizes the signs and symptoms of trauma in clients, families, staff and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures and practices to actively resist re-traumatization.

The Four R's of a Trauma-Informed Approach

A trauma-informed approach can be understood through the terms **realization**, **recognition**, **responding** and **resisting**.

REALIZATION — all those involved in your organization at all levels realize that:

- Trauma can affect individuals, families, organizations and communities
- People's behaviors can be understood as coping strategies designed to survive adversity and overwhelming circumstances (past or present)

RECOGNITION — all those involved in your organization are able to recognize the signs of trauma and have access to trauma screening and assessment tools

RESPONDING — your organization responds by applying a trauma-informed approach to all aspects of your work. Specifically, everyone on staff in every role has changed their behaviors, language and policies to take into consideration the experiences of trauma among residents, their families and staff. Other ways this response is manifest include:

- Ensuring that the materials used in your organization — from your mission statement to manuals to policies and procedures — reflect your commitment to creating a culture of resilience, recovery and healing from trauma
- Formalizing ways for people who have experienced trauma to advise and guide the organization
- Providing staff training and guidance for supervisors on secondary traumatic stress
- Articulating your commitment to a physically and psychologically safe environment and to fairness and transparency (others would include a culture of social and moral safety)
- Adopting a universal precautions approach that assumes the presence of trauma in the lives of residents and takes steps to not replicate trauma

RESISTING re-traumatization of residents and staff members by ensuring that practices do not create a toxic environment — for example understanding the impact of using restraints or seclusion on a resident with a trauma history

The Six Key Principles of a Trauma-Informed Approach

SAFETY — all people associated with the organization feel safe. This includes the safety of the physical setting and the nature of interpersonal interactions.

TRUSTWORTHINESS AND TRANSPARENCY — your organization is run with the goal of building trust with all those involved.

PEER SUPPORT — support from other trauma survivors is a key to establishing safety and hope.

COLLABORATION AND MUTUALITY — recognition that everyone at every level can play a therapeutic role through healing and safe relationships. Your organization emphasizes the leveling of power differences and taking a partnership approach with all staff.

EMPOWERMENT, VOICE AND CHOICE — your organization recognizes and builds on the strengths of your people — staff members and residents. You recognize the ways in which nursing home residents and staff members have historically been diminished in voice and choice and have at times been subject to coercive treatment. You support and cultivate skills in self-advocacy, and seek to empower residents and staff members to function or work as well as possible with adequate organizational support.

CULTURAL, HISTORICAL AND GENDER ISSUES — your organization actively moves past cultural biases and stereotypes (gender, region, sexual orientation, race, age, religion), leverages the healing value of traditional cultural traditions, incorporates processes and policies that are culturally aware and recognize and address historical trauma.

KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

Safety
Trustworthiness & Transparency
Peer Support
Collaboration & Mutuality
Empowerment, Voice & Choice
Cultural, Historical & Gender Issues

The Ten Domains for Implementing a Trauma-Informed Approach

While implementation will be the subject of a future toolkit, it is worth becoming aware of the dimensions of your organization's functioning — or domains — that will be involved in this process when the time comes to operationalize a trauma-informed approach. Those domains are:

- Governance and Leadership
- Policy
- Physical Environment
- Engagement and Involvement — of people in recovery, trauma survivors, residents and family members, and staff at all levels
- Cross-Sector Collaboration — all levels, departments, and teams
- Screening, Assessment, Treatment Services
- Training and Workforce Development
- Process Monitoring and Quality Assurance
- Financing
- Evaluation

> [Trauma-informed care] believes everyone possesses resilience and the ability to heal and asks the question, 'what happened to you?'
>
> —*Mitchell & Kay*

FUNDAMENTAL PRINCIPLES AND PRACTICES

Working with people who have experienced trauma

Across the literature concerning trauma-informed approaches, there emerge core principles and practices that have value not only for those who have experienced trauma but also for everyone for whom we provide care. As researchers and practitioners have gained knowledge and experience in understanding and working with the impact of traumatic experiences, they have gained insights into the ways in which difficult life experiences impact all of us.

Presenting about trauma-informed care with older adults, Alison Mitchell, MA, MSW and Len Kay, Ph.D., DSW of the University of Maine Center on Aging suggest that at the individual level trauma-informed care, "recognizes that everyone experiences difficulties, understands that adversity shapes how we react and behave, believes everyone possesses resilience and the ability to heal, and asks the question, 'what happened to you?'[14] The assertions in Mitchell and Kay's presentation align with recommended approaches for working with individuals who have experienced trauma that come out of work across multiple population segments, from children to veterans to older people. Drawing from their work and that of a number of other sources, we offer a distillation of the key learnings from the field, organized into core principles and practices.

Core Principles

There are three core principles that guide trauma-informed care:

1. **The impact of adversity is not a choice.**
2. **Understanding adversity helps us make sense out of behavior.**
3. **Prior adversity is not destiny.**

PRINCIPLE 1: THE IMPACT OF ADVERSITY IS NOT A CHOICE.

Adverse or difficult life experiences affect all of us in ways that are more about neurophysiology and less about character than most of us have supposed.

Despite the commonly shared belief that 'what doesn't kill us makes us stronger,' the evidence from neurobiology and public health increasingly demonstrates that adversity causes changes in the brain and body that occur outside our awareness and are not subject to being overridden by 'grit' or toughness. In addition to the clear findings of the ACEs study and subsequent studies on the powerful connection between childhood adversity and later health challenges, from autoimmune diseases (e.g. lupus, multiple sclerosis, rheumatoid arthritis) to diabetes, heart disease, stroke, cancer and COPD, scientists are increasingly able to explain the mechanisms behind these negative health consequences as well as the ways in which adverse experiences in childhood permanently change the developing brain.

The neurobiology of toxic stress — human bodies have evolved to respond effectively to external stressors, whether to wild animals earlier in human history or to threats of violence, illness or psychological threats in our current environment. Humans' normal physiological reactions to external stressors include increased heart rate, surges in hormones like cortisol and norepinephrine and the temporary shut down of higher brain function — sometimes called an 'amygdala hijack' — all of which enable us to quickly assess whether we need to literally or metaphorically fight, flee or freeze in place.

> "Even one acute traumatic experience – sometimes called single incident trauma – can change the brain in harmful ways.

When a child experiences adversity that is intense and/or prolonged — especially in the absence of consistent adult support — this normal bodily stress response remains activated or never really turns off. This kind of prolonged activation of the stress response can disrupt the ongoing development of the child's brain and other organ systems and set the stage for stress-related diseases and cognitive impairments throughout the lifespan.

Neurological changes from single incident trauma — recent research has demonstrated that even one acute traumatic experience — sometimes called single incident trauma — can change the brain in harmful ways. Professor Sumantra Chattarji of India's National Centre for Biological Science has shown that ten days after one such single incident trauma laboratory rats show increased anxiety and their brains show changes in the structure of the amygdala.

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▶▶▶ *Impact of Adversity Continued.*

Genetics and the risk for post-traumatic stress response — the National Institutes of Health's National Center for Biotechnology Information reports the following:

> *There is accumulating evidence that risk for PTSD is heavily influenced by genetic factors. Evidence from family and twin studies has long suggested a heritable contribution to the development of PTSD. In addition, there is evidence for heritable contributions to some of the neurobiological endophenotypes of PTSD [...] such as decreased hippocampal volume or exaggerated amygdala reactivity.* [15]

In other words, the genetic makeup we inherit makes some of us more likely than others to experience difficult events as traumas that, in turn, produce health-damaging traumatic stress.

PRINCIPLE 2: UNDERSTANDING ADVERSITY HELPS US MAKE SENSE OUT OF BEHAVIOR.

We cannot fully understand behavior or respond to it effectively without understanding prior adverse experiences.

In working with older adults, clinical and non-clinical staff members are continuously — consciously and deliberately or unconsciously — observing behavior and interpreting what that behavior means. Some of this is an ongoing process with all human interactions. Some of this observation and meaning-making comes from the training staff members receive in their professional disciplines.

When considering what observed behavior might mean, we use a number of different rubrics, among them considerations about possible medical reasons, psychosocial causes, and environmental factors. For example, a resident who seems agitated might be viewed as potentially reacting to medication, exhibiting signs of cognitive decline, reacting to an interaction with a family member or fellow resident, or to something in his or her physical space that is causing distress. Staff members sometimes assess the situation on their own, or confer with colleagues and with the resident.

While all of this may be good practice, the capacity to assess the meaning of behavior is incomplete without the addition of a consideration of prior adversity. A trauma-informed approach to assessing behavior does not take precedence over other rubrics — it adds an essential missing piece to the puzzle that can help make sense out of puzzling behavior and informs our understanding about why our interventions sometimes are ineffective or even backfire.

In a person-centered approach, it might seem obvious that the way to factor in the impact of prior adversity would simply be to ask the resident. While this can be an effective approach, it is important to remember that individuals don't always recognize the role that prior adversity plays in their lives. In fact, it may be true that older adults are less likely to acknowledge their trauma histories and its impact on them than younger people. The fact that some older adults are experiencing cognitive impairment may further complicate the issue. ▶▶▶

▶▶▶ *Understanding Adversity Continued.*
Psychologist Joan Cook, quoted above on the potential for older adults to minimize or deny prior trauma, went on to comment on the persistence of this pattern even in an environment in which awareness of traumatic experience is more common and more normalized:

> *I think events such as the September 11th terrorist attacks, the wars in Iraq and Afghanistan, and Hurricane Katrina, have helped raise the national consciousness about trauma. But I still clinically come across older adults who lack an understanding of the potential effects of traumatic experiences or don't accurately label such events as "traumatic." In addition, there are also cognitive, sensory, and functional impairments that may affect the experience, impact, or reporting of trauma-related symptoms.* [16]

Fortunately, there are tested approaches that enable staff members to elicit residents' lived experiences in sensitive ways that can help identify the role that trauma may be playing in their current lives. While the process is not as simple as asking one or two questions, this process can be done in straightforward ways that are effective and, at the same time, avoid the risk of inadvertently re-traumatizing the individual.

A few examples of behaviors that may stem from prior trauma and can easily be misunderstood include the following:

Hoarding — while it is easy to think that hoarding behavior results from experiences of poverty earlier in life, in fact hoarding correlates not with this kind of deprivation but instead with histories of physical abuse, including sexual abuse, in childhood. In fact, one in four adults who exhibit hoarding behavior report physical abuse or maltreatment, while more than one-quarter report forced sexual activity in childhood. Many of these adults (31%) have, earlier in their lives, had their possessions taken from them by force.[17] While not all individuals who display hoarding behavior have a trauma history, this data suggests that prior adverse experiences are important to consider as a potential contributing factor.

Other Unsafe Behaviors — Gabriella Grant, Director of the California Center of Excellence for Trauma-Informed Care, points out that current unsafe behaviors in older people should be considered red flags for prior child abuse; specifically, she points to:

- Re-victimization (domestic violence, elder abuse)
- Depression
- Suicidal behaviors
- Self-harming and self-neglect
- Dementia or delirium diagnoses
- Drug use, alcohol use and smoking
- Multiple, chronic, complex illnesses
- Insomnia, eating disturbances, poor self-care
- Helplessness, hopelessness, pessimism
- Noncompliance with medication and treatment[18]

Grant also cites prior published work on the impact of undiagnosed child sexual abuse on older adults to point to common misdiagnoses made of older people with trauma histories, including:[19]

- Chronic depression
- Dementia
- Personality disorders (borderline, narcissistic, antisocial)
- Bipolar and schizophrenic

Given the frequency with which staff members in nursing home settings encounter these behaviors and diagnoses, the addition of a trauma-informed lens to the process of assessing and responding to observed behavior represents an important new tool in the tool set in wide use in our field.

PRINCIPLE 3: PRIOR ADVERSITY IS NOT DESTINY.

In an environment of safety and support, change, healing and better lives are possible.

There are two key dimensions to emphasize regarding the potential for older people who have experienced adversity to thrive: the role of individual human potential and the role of a supportive environment.

Human potential for healing across the lifespan — beyond the evidence and practice wisdom from multiple fields that focus on the physical, mental and spiritual health of individuals, there exists data on the impact of psychological interventions with older adults. This includes the kinds of trauma-specific interventions that may be offered through behavioral health services, along with insights from neurobiology that help explain how greater resilience and healing is possible even after the brain is impacted by traumatic stress.

Reporting on meta-analyses conducted of psychological interventions for the treatment of depression in later life, the American Psychological Association's Psychotherapy and Older Adults Resource Guide points out that the aggregate effect size in older adults is roughly equal to that in younger adults. In other words, the Guide explains, "In general, then, available evidence supports the effectiveness of psychological interventions with older adults, for those interventions that have been studied."[20]

> "In the past, the belief was that the brain was fully developed by early adulthood. It is now broadly recognized that the brain is able to change over the lifespan...
>
> — *Laura Leitch*

Neuroplasticity — the ability of the brain to change — lasts a lifetime — in writing about the use of trauma-informed care and the ACEs research in fostering resilience among people impacted by trauma, Laura Leitch writes in the National Institutes of Health's Health Justice journal (April 2017): "Another neuroscience finding that can contribute to a shift from information to action in TIC [trauma-informed care] is the ability of the brain to change.[21] In the past, the belief was that the brain was fully developed by early adulthood. It is now broadly recognized that the brain is able to change over the lifespan..." Because the brain can continue to change in older adults, methods developed to harness neuroplasticity in response to the impact of traumatic stress are promising for this population as well, among them tools for attentional focus and self-regulation, including meditation, and neuroeducation that helps affected individuals understand what they are experiencing and use techniques for downshifting acute responses to allow for other options and to increase a sense of mastery and efficacy.

▶▶▶ *Prior Adversity Continued.*

The role of a safe and supportive environment — because adverse or traumatic experiences, by definition, are the result of a lack of safety and make affected individuals feel unsafe, subsequent environments have the potential to either exacerbate the feeling of threat and danger or mitigate it. A safe environment creates a setting in which manifestations of traumatic stress are minimized and individuals experience greater comfort and opportunity for well-being and healing. The literature on trauma-informed care across populations and settings is nearly universal in its emphasis on the importance of creating an environment that is, and is experienced as, both physically and emotionally safe.

> "Like safety, social support is a hallmark of all trauma-informed approaches.

While the specific steps involved in assessing the safety of your organization's environment through a trauma-informed lens will be addressed later in this publication and in subsequent tools, it is important to remember that the ways in which a setting may feel safe or unsafe are not limited to those you customarily consider in your current safety protocols. There are broad dimensions to these considerations and others that need to be understood relative to the affected individual.

Like safety, social support is a hallmark of all trauma-informed approaches and is considered a key factor in both mitigating the impact of adverse experiences as they occur and in enabling individuals to develop resilience afterwards. In nursing home communities this support can come from fellow residents, family members and other friends, and from staff members. In an environment that is safe and supportive, residents with trauma histories can function better, experience a great sense of well-being and improved health outcomes, and can engage in trauma-specific behavioral health treatment when it is available and when the resident chooses it.

Core Practices

In working with individuals who have experienced trauma outside of the behavioral health treatment context, there are three main practices all staff members should understand and be prepared to use:

1. **Asking about and screening for trauma**
2. **Identifying triggers**
3. **De-escalation**

1. ASKING ABOUT AND SCREENING FOR TRAUMA

Lisa M. Brown, PhD Director of the Trauma Program at Palo Alto University, offered the following guidance on how to sensitively inquire about an older adult's history of trauma in her 2013 presentation entitled Assessing, Intervening, and Treating Traumatized Older Adults:[22]

General Assessment Considerations:

- Inquire in a physically private and safe setting
- Avoid the common pitfalls of negative inquiries and labeling words/phrases
- Echo the patient's words or concerns
- Normalize, but don't minimize
- Validate, validate, and validate

▶▶▶

▶▶▶ *Asking & Screening for Trauma Continued.*

Brown goes on to offer specific language that can be used to introduce the relevant line of questioning:

> *"Because most people have had difficult experiences at some point during their life, I've begun to ask about them routinely."*
>
> *"Some people have told me about difficult experiences they had during their lifetimes, such as being threatened or ___. Has anything like that ever happened to you?"*

She then goes on to offer guidance on how to respond — and how not to respond — to disclosures of prior trauma:

Do:

- Normalize reactions and responses:
  - "You are not alone."
  - "I know that this has happened to others."
  - "Many people have had these experiences and are deeply affected by them. They often feel angry, embarrassed, and fearful for some time afterwards. It is an understandable reaction to a very frightening experience."
- Validate the experience and its effects:
  - "That must have been very frightening."

Don't:

- Appear to doubt or disbelieve the person's account of what happened.
- Inquire about details of the trauma episode at this time.
- Ask questions or make statements that suggest that you hold the person responsible for this incident like:
  - "What were you doing in a place like that?"

RESPONDING TO DISCLOSURES OF TRAUMA

DO:

- Normalize reactions and responses.
- Validate the experience and its effects.

DON'T:

- Appear to doubt or disbelieve the person's account.
- Inquire about details of the trauma episode.
- Ask questions or make statements that suggest you hold the person accountable for the incident.

From Lisa M. Brown, PhD

> "Distinguish between thinking and asking 'what's wrong with you?' and 'what happened to you?'

Gabriella Grant of the CA Center of Excellence for Trauma-Informed Care offers a short screening she developed and calls the 'briefest screen ever,' made up of three questions, adapted here slightly for use in a nursing home context:

- Do you feel safe speaking to me today? If not, what would help you feel safer?
- Do you feel safe being here/living here today? If not, how can we help you feel safer?
- Did you feel safe at home as a child? If not, how does that affect you today?

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▶▶▶ *Screening for Trauma Continued.*

Grant also offers four universal precautions to take in working with older adults with trauma histories:

- If there is no specific information, assume trauma!
  - Notice if thinking trauma first provides more solutions
  - Alternative to finding blame, feeling overwhelmed, triggered, struggling to know what to say
- Ask how this still affects elder today — redirect to the present.
- If disclosure, recognize the bravery and ask what the person would like to do, if anything.
- Know mandated reporting laws and speak to supervisor after any disclosure.

Another way of thinking about the process of assessing and inquiring about prior trauma history is a distinction that is drawn frequently across the literature on trauma-informed approaches, between thinking or asking "what's wrong with you?" and thinking or asking "what happened to you?" By starting with the premise that current behavior is shaped by prior experiences, staff members will better be able to stay out of snap judgments or quick classification and instead stay present to the possibility of prior adverse experiences that can be inquired about and understood.

> "A trigger is any sensory reminder of the traumatic event: a noise, smell, temperature, other physical sensation, or visual scene."
>
> - *SAMHSA*

2. IDENTIFYING TRIGGERS

In interacting with individuals with a history of trauma, it's important to understand that occurrences, including sensations, happening in the present time can palpably evoke the traumatic experience, often without the individual even realizing that this is occurring. These occurrences are referred to as trauma triggers, and are defined in the SAMHSA publication on trauma-informed care in behavioral health the following way:

> *A trigger is a stimulus that sets off a memory of a trauma or a specific portion of a traumatic experience. Imagine you were trapped briefly in a car after an accident. Then, several years later, you were unable to unlatch a lock after using a restroom stall; you might have begun to feel a surge of panic reminiscent of the accident, even though there were other avenues of escape from the stall. Some triggers can be identified and anticipated easily, but many are subtle and inconspicuous, often surprising the individual or catching him or her off guard [...] A trigger is any sensory reminder of the traumatic event: a noise, smell, temperature, other physical sensation, or visual scene. Triggers can generalize to any characteristic, no matter how remote, that resembles or represents a previous trauma, such as revisiting the location where the trauma occurred, being alone, having your children reach the same age that you were when you experienced the trauma, seeing the same breed of dog that bit you, or hearing loud voices. Triggers are often associated with the time of day, season, holiday, or anniversary of the event.* [23]

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▶ ▶ ▶ *Identifying Triggers Continued.*

Later, the publication recommends that professionals help with identifying triggers:

> *In treatment, it is important to help clients identify potential triggers, draw a connection between strong emotional reactions and triggers, and develop coping strategies to manage those moments when a trigger occurs.*

One way of identifying potential triggers is for individuals to consider what situations s/he finds stressful or overwhelming and reminds him/her of past adverse experiences.

In their trauma-informed organizational toolkit the National Center on Family Homelessness describes triggers as "reminders of dangerous or frightening things that have happened in the past" and offers examples of feelings that may arise, including helplessness, rage, sadness, and terror.[24]

> "De-escalation allows the individual to return from the 'there and then' to the 'here and now.'

3. DE-ESCALATION

Knowing that a person with a trauma history, when triggered, is likely having a traumatic stress response that physiologically mimics a state of imminent threat (heart racing, fight-flight-freeze response, dissociation, strong emotions), the keys to de-escalation are to help create a sense of calm and safety that allows the individual to return from what's sometimes called the "there and then" to the present moment or "here and now." Some tips from those working in the field include:

- Remain calm and connect in a gentle, positive way — avoid raised voices or harsh tones. Be cautious about physical contact.
- Help redirect attention in ways that are grounding, like noticing out loud physical sensations and things in the physical environment — the floor beneath our feet, the chair you're sitting on.

To make de-escalation more effective with individuals with a known trauma history (and beyond that, for all and not just those with known trauma histories), a staff member can work with him/her to create a personalized safety plan that provides guidance on what to do when s/he is triggered. This can be used not only when people are feeling physically unsafe, but also when feelings may be overwhelming. A self-care plan may also be created that helps the individual think about how to stay healthy and to anticipate and manage stressors. In both these plans, the activities planned can include things like: comforting smells; familiar music with positive associations; pictures of places perceived as safe, etc. The Trauma-Informed Organization toolkit recommends the development of this kind of a plan, and suggests that it be written down and — if the individual is willing — shared with all staff members and others interacting with him or her. That plan would include:

- A list of situations that the resident finds stressful or overwhelming and remind him/ her of past traumatic experiences (i.e., triggers)
- Ways that the individual shows that he/she is stressed or overwhelmed (e.g. types of behaviors, ways of responding, etc.)
- Staff responses that are helpful when the resident is feeling upset or overwhelmed
- Staff responses that are not helpful when the resident is feeling upset or overwhelmed
- A list of people to go to for support

> Lack of awareness and understanding trauma increases the risk of doing additional harm.
>
> —*Mitchell & Kay*

Toward creating a trauma-informed organization

Trauma-informed care is much more than an approach to interacting with individuals on a one-on-one basis. To provide care that is trauma-informed, it is not only the care itself that must be trauma-informed, but also the organization writ large. In other words, the journey toward providing trauma-informed care includes, but is not limited to, changing the way we provide services and supports to individuals. A true trauma-informed approach extends further, and includes not only the ways we interact with individuals inside and outside of formal service provision but also the ways in which the larger organizational culture, climate and functions are transformed to themselves become trauma-sensitive. This kind of truly trauma-informed organization achieves two outcomes that are key to ensuring that residents with trauma histories can live well and achieve their highest potential: 1) the organization offers an environment that feels and is safe and supportive for all people who have prior traumatic experiences and 2) the organization avoids, even unintentionally, creating conditions that can re-traumatize and thus further harm individuals who have already been impacted by adverse life experiences.

Re-traumatization

The risks of re-traumatization are well-described in the trauma-informed organizational framework created for use in groups serving veterans:

> *Lack of awareness and understanding trauma increases the risk of doing additional harm. Veterans who have experienced trauma [...] may exhibit a variety of post-trauma responses in service settings. These behaviors can be best understood as adaptive responses to manage overwhelming stress. However, without understanding the connection between trauma and current behaviors, providers may mislabel a veteran as "oppositional," "lazy," or "unmotivated." These types of negative labels impact how providers respond to veterans and the quality of services veterans receive. Service environments may also inadvertently trigger post-trauma responses in veterans. Common experiences in service settings (e.g. being asked personal questions on assessments, long waits, strict rules) may trigger the activation of a post-traumatic stress response leading to heightened reactions that may be misunderstood by providers to be purposefully offensive, rude or aggressive. Finally, without an understanding of trauma and its impact, service providers run the risk of re-traumatizing the veterans they serve. Survivors, veteran or civilian, who are further traumatized within service systems by unrealistic demands and harsh responses by staff become increasingly wary of and triggered by all people's efforts to help and may drop out of VA or community-based services altogether.* [25]

In a nursing home setting, some of the ways the impact of re-traumatization might manifest could include withdrawal from enrichment activities or social contact with other residents, lack of interest in food, wariness about medical or other health services and behavior that might appear oppositional with staff.

Vicarious or Secondary Trauma

It should be noted at this point that a trauma-informed organization pays close attention to creating trauma-sensitive conditions for residents and also for staff. Given the prevalence of adverse experiences across the population, it is clear that many staff members themselves bring trauma histories to their work with our organizations. Further, the experience of working with residents who have trauma histories is itself a risk factor for what is known as vicarious or secondary trauma.

> "Transforming your organization into one that is truly and consistently trauma-informed is in fact a systems change effort.

The phenomenon of vicarious or secondary traumatic stress is well-documented in the literature. This term refers to the impact on those who work closely with clients who have experienced trauma, in which caregivers, therapists and other professionals are themselves traumatized by hearing about those experiences and then themselves exhibit post-traumatic stress symptoms. The National Child Traumatic Stress Network reports that from 6% to 26% of therapists working with traumatized populations, and up to 50% of child welfare workers, are at high risk of secondary traumatic stress or the related conditions of PTSD and vicarious trauma.[26]

> It will involve all the major functions of your organization as well as all staff, and will require steady commitment over time.

Systems Change

In their publication *Systems Change: What it is and How to Do It*, authors Rob Abercrombie, Ellen Harries and Rachel Wharton define systems change as

> *...An intentional process designed to alter the status quo by shifting the function or structure of an identified system with purposeful interventions. It is a journey which can require a radical change in people's attitudes as well as in the ways people work. Systems change aims to bring about lasting change by altering underlying structures and supporting mechanisms which make the system operate in a particular way. These can include policies, routines, relationships, resources, power structures and values.* [27]

By this definition, transforming your organization into one that is truly and consistently trauma-informed is in fact a systems change effort. As you embark on this journey, it is important to recognize that scope of this change process and the reality that it will involve all the major functions of your organization as well as all staff, and will require steady commitment over time. The journey to becoming a trauma-informed organization cannot be wholly delegated to a department or task force, nor can it be achieved solely through the commitment and efforts of one or a few organizational leaders.

Functions Involved in Trauma-Informed Systems Change

While it might initially seem that your Human Resources or Training functions would largely lead this process, in fact, as cited earlier from the SAMSHA guidance, this work will span at least the ten domains elaborated in that publication. In thinking about a nursing home community, we would suggest the following list to highlight functional areas that will need to be involved in this process.

- Administration
- Quality Assurance and Performance Improvement
- Facilities Management / Environmental Services
- Intake and Assessment
- Physical, Occupational and Speech Therapy
- Medicine and Behavioral Health
- Nursing
- Dietary Services
- Social Work / Social Services
- Activities / Life Enrichment
- Discharge Planning
- Human Resources
- Training and Workforce Development
- Dining / Food Services
- Finance
- Security

▶▶▶ *Functions Involved Continued.* While some of these functions may be performed under contract by outside providers, these professionals will, like your staff members, need to be trained on trauma, traumatic stress and trauma-informed approaches so that their interactions with residents and colleagues will also reflect the requisite knowledge, attitudes and skills.

Five Key Steps in the Process

While the change process to become trauma informed at the organizational level will be detailed in subsequent toolkits and webinars, we believe it is useful to offer you a broad brush picture of that process, described as a series of steps.

FIVE STEPS OF TRAUMA-INFORMED SYSTEMS CHANGE

STEP 1: ENGAGING AND EMPOWERING LEADERS

To successfully begin this change process, organizations are encouraged to have strong and explicitly articulated buy-in from the chief executive and senior management and should assemble and appoint a multidisciplinary task force or working group to lead the initiative. Experience from multiple fields undertaking this work argues persuasively that the task force should be composed of staff members from key organizational functions and from different levels.

> "Buy-in from all key stakeholders is vital for this initiative to take hold.

The Task Force will set goals and establish core values for the initiative, in conjunction with senior leadership, and will keep the work moving forward throughout the process. Task Force members also serve as champions of the work throughout the organization.

STEP 2: LAUNCH AND INITIAL TRAINING

Many organizations launch this initiative with a kickoff event, which often includes an initial training session for all staff, covering core concepts of trauma, traumatic stress, its impact and its importance in your organization's work.

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> You will want to continue to offer professional development for staff members on the ways in which a trauma-informed approach can be integrated into their work.

STEP 3: ORGANIZATIONAL ASSESSMENT

In order to know which areas of your organization will require what amount — and what kinds — of work in this effort, experienced practitioners recommend conducting a trauma-informed organizational assessment. A future toolkit will offer you a simple assessment tool along with information on validated instruments that assess your organization in greater depth. When you conduct this assessment or series of assessments, it will also be important to create an evaluation and accountability plan detailing how you will determine the extent to which your efforts are having the impact you seek.

STEP 4: INVOLVING RESIDENTS, FAMILIES AND COMMUNITY PARTNERS

Buy-in from all key stakeholders is vital for this initiative to take hold, and so developing forums and means for engaging your residents, their family and friends, and your partner organizations is an important step. Among the ways to involve others is to provide what is sometimes called psychoeducation or neuroeducation — that is, training that helps others understand the essentials of trauma, how traumatic stress manifests and what is possible in terms of self care, self advocacy and healing.

STEP 5: ONGOING TRAINING AND SUPERVISION

As you continue on the trauma-informed care journey, you will want to continue to offer professional development for staff members, sometimes by professional discipline, on the ways in which a trauma-informed approach can be integrated into their work. Information on your organization's commitment to trauma-informed care should also be built in to staff onboarding and volunteer orientation sessions. In order to embed this approach, it is also essential that staff supervisors be trained and supported in inquiring about and coaching on trauma-informed approaches as a part of their ongoing work with all staff.

STATEMENT OF INTENT

As you undertake the journey of adopting trauma-informed approaches to care in your organization, we encourage you to review and adopt the following Statement of Intent, or something similar, as a formal indication of your understanding of what is involved and your commitment to enhancing your ability to provide person-centered care to residents who have experienced trauma.

As an organization, we are committed to learning about trauma and its effects and to engage with and implement trauma-informed approaches to the care we provide and the organizational culture we create.

We understand that:

- Trauma-informed care is an important component of enacting our commitment to person-centered care through which we offer individualized support and services that are responsive to our residents' wishes and goals;
- Our work will be informed by the guidance offered to us by the Substance Abuse and Mental Health Services Administration in its 2014 publication, *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach;*
- Trauma impacts a significant portion of the population across the lifespan and produces physical, mental and social health outcomes that complicate aging and can, if unrecognized, be misunderstood as manifestations of other conditions and disorders and thus subject to inappropriate treatment;
- Residents who have a trauma history deserve access to care that is trauma-sensitive and behavioral health treatment, as appropriate, that is trauma-specific;
- Our organization can and should have an organizational culture that is trauma-responsive and so avoids re-traumatizing residents and creates an environment of safety;
- Our staff members will need skills and guidance on identifying symptoms of trauma, talking with residents about trauma, and acting in a trauma-responsive manner;
- Our staff members deserve an environment and supports that acknowledges their own experiences of trauma and that working with residents with trauma histories can result in secondary or vicarious trauma for staff;
- We intend to involve our residents and their families as well as staff members and community partners in this journey through education and opportunities to provide input;
- As leaders, we must demonstrate our commitment to this approach and to sponsoring the systems change process involved in creating a trauma-informed culture;
- The work of implanting trauma-informed care and creating a trauma-informed culture takes time, the investment of resources, and accountability mechanisms;
- We are committed to full implementation of the trauma-informed care requirements as codified in the CMS Final Rule — these requirements pertain to comprehensive person-centered care planning (42 CFR 483.21(b)3(iii), quality of care (42 CFR 483.25) and behavioral health services (42 CFR 483.40).

CONCLUSIONS AND NEXT STEPS

Incorporating a trauma-informed approach in our work with residents offers us the opportunity to significantly improve our organizational capacity to provide a high quality of life, health and well-being for all we serve. As we move through the process of organizational transformation, all staff members across the organization will develop new skills and knowledge and will experience a difference in the work environment in the process.

By working with this Foundations primer well in advance of the date these requirements go into effect, you are laying a foundation for trauma-informed care that is better grounded in the research and in the experiences of organizations who have been successful in taking this journey. As a result, we believe you and your team are more likely to successfully implement this approach and to yield multiple benefits for residents, staff and all who are a part of your community.

Endnotes

[1] "CMS Finalizes Improvements in Care, Safety, and Consumer Protections for Long-term Care Facility Residents," *Center for Medicare and Medicaid Services*, September 28, 2016, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-09-28.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending.

[2] Please note that for purposes of this paper and for ease of communication we are using the term "resident" to refer to individuals receiving care in a nursing home community. We do so cognizant of the fact that many communities provide rehabilitative care of shorter duration, and in those cases individuals are typically referred to as patients or using other terms.

[3] For ease of reading, the terms "post-traumatic stress" and "PTSD" will be used interchangeably throughout this publication.

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[6] Yoram Barak and Henry Szor, "Lifelong Post-traumatic Stress Disorder: Evidence from Aging Holocaust Survivors," *Dialogues in Clinical Neuroscience* (March 2000).

[7] Leaders of nursing home communities often experience difficulty identifying and accessing behavioral health resources for residents, particularly practitioners with expertise in working with older people. Further suggestions for addressing behavioral health needs of residents and staff members who have experienced trauma will be offered in subsequent tools and resources.

[8] Roger D. Fallot and Maxine Harris, *Community Connections: Creating Cultures of Trauma-Informed Care: a Self-Assessment and Planning*. PDF Protocol © 2009.

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[12] Shaili Jain, "The Golden Years: Traumatic Stress and Aging: An Interview with Joan Cook," *Psychology Today*, October 20, 2016, https://www.psychologytoday.com/blog/the-aftermath-trauma/201610/the-golden-years-traumatic-stress-and-aging.

[13] Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-14884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

[14] Allison Mitchell, and Len Kay, "Trauma-Informed Care with Older Adults," PDF, 24th Annual Maine Geriatrics Conference, Bar Harbor, ME, June 12, 2014.

[15] Jonathan E. Sherin and Charles B. Nemeroff, "Post Traumatic Stress Disorder: the Neurobiological Impact of Psychological Trauma," *Dialogues in Clinical Neuroscience* (September 2011).

[16] Shaili Jain, *Psychology Today*, October 20, 2016.

[17] Tamara L. Hartle, Shannon R. Duffany, George J. Allen, Gail Steketee, Randy O. Frost, "Relationships Among Compulsive Hoarding, Trauma, and Attention-Deficit/Hyperactivity Disorder," *Behaviour Research and Therapy* Volume 43, Issue 2, February 2005, Pages 269-276.

[18] Utah Division of Substance Abuse and Mental Health Services Administration. *Working with Elders Who Have Trauma Histories*, Gabriella Grant, California Center of Excellence for Trauma Informed Care, Utah Fall Conference, 2014.

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[20] Bob G. Knight. 2009. "Psychotherapy and Older Adults Resource Guide." Updated: October 2009, http://www.apa.org/pi/aging/resources/tuides/psychotherapy.aspx.

[21] Laura Leitch, "Action steps using ACEs and trauma-informed care: a resilience model," Health & Justice 2017, https://doi.org/10.1186/s40352-017-0050-5

[22] Lisa M. Brown, *Assessing, Intervening, and Treating Traumatized Older Adults*, 4th biennial trauma conference, Addressing Trauma Across the Lifespan: Integration of Family, Community, and Organizational Approaches, Pikesville, MD, October 2013.

[23] *Trauma-Informed Care in Behavioral Health Service, Treatment Improvement Protocol (TIP) Series*, No. 57, Center for Substance Abuse Treatment (US). Rockville, MD, 2014.

[24] Kathleen Guarino, et al., (2014)

[25] Ibid., p. 3

[26] National Child Traumatic Stress Network, Secondary Traumatic Stress Committee. "Secondary Traumatic Stress: a Fact Sheet for Child-serving Professionals." Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress (2011).

[27] Rob Abercrombie, Ellen Harries, and Rachel Wharton, *Systems Change: What It Is and How to Do It*, New Philanthropy Capital, London, U.K., June 2015.