# Fostering Safety and Trust Through Trauma-Informed Practices

Jess Mather

CPT, LPTA, SFG, FRCms, FMS

“We are customer service first.”

“The quality of our life is dependent on the quality of our relationships.”

Trauma often happens in relationship.

If you are a healthcare provider, there is a high likelihood you'll encounter clients with trauma.

- How do we help these clients feel safe?
- How do we help these clients lower their guard?
- How do we help these clients trust us?
- How do we help these clients follow our lead?

“It’s not what you do, it’s how you do it.”

This is a continuing education course to understand symptoms of relational trauma and how to build greater safety and trust with this population.

Safety and trust form the foundation of our work as healthcare providers.

# What are our objectives?

# Objectives

- Identify what  trauma and trauma-informed care are to demonstrate greater compassion for our clients and others.

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- Define somatics and its role in safety and connection.

# Jess Mather

CPT, LPTA, SFG, FRCms, FMS

Jess Mather, CPT, LPTA. SFG, FRCms, FMS, is a strength and rehabilitation professional dedicated to helping individuals experience less limitation, pain, fear, and insecurity in their bodies. With over 13 years of experience, she has supported thousands of clients aged 9 to over 99, witnessing firsthand the body's remarkable ability to adapt, strengthen, and heal.

Since 2015, Jess has operated a successful telehealth practice, offering private coaching, courses, and group programs to clients in over a dozen countries. Her expertise extends to educating other therapists and healthcare providers on effectively supporting patients with complex chronic pain, trauma, and stress.

# What are *you* here for?

What are you hoping to take away from this material *professionally*?

What are you hoping to take away from this material *personally*?

What I want for you is a new perspective on how to work with people with trauma.

More confidence in the work that you’re doing and how you’re serving.

New tools and skills to apply to yourself and your clients.

More compassion for yourself and others.

An appreciation for how intelligent our brain, body, and nervous system are at protecting us.

# CHAPTER REVIEW

# Chapter 1: Understanding Trauma and Trauma-Informed Care

- Exploring what trauma and trauma-informed care are to demonstrate greater compassion for our clients and others

# Chapter 2: Relationships, Touch, and the Healing Power of Connection

- Highlighting the benefits of social connection, touch, and therapeutic relationships for those with complex trauma

# Chapter 3: Attachment Theory

- How our earliest attachments in life can set the stage for the relationships we have later in life

# Chapter 4: Safe Connection Through Co-Regulation

- The science behind “good bedside manner” exploring co-regulation and its importance to a client’s success

# Chapter 5: Autonomy and Boundaries

- How to support our patients' autonomy and boundaries so they can maneuver through medical treatments without losing their voice

# Chapter 6: Trauma-Informed Principles for Business and Marketing

- Bringing trauma-informed care into the way we market to clients and conduct our business

# Let’s begin!

# Chapter 1: Understanding Trauma and Trauma-Informed Care

- Exploring what trauma and trauma-informed care are to demonstrate greater compassion for our clients and others

# What is trauma?

At least 223.4 million people in America have experienced trauma.

How to Manage Trauma (n.d.)

National Council for Mental Well-Being reports that in public behavioral health, over 90% of clients have experienced trauma.

How to Manage Trauma (n.d.)

The American Psychological Association states, “A traumatic event is one that threatens injury, death, or the physical integrity of self or others and also causes horror, terror, or helplessness at the time it occurs.”

American Psychological Association (2021)

Trauma occurs when something is too much, too fast, or too soon.

“Trauma is not what happens to you, it's what happens inside of you as a result of what happened to you.”

—*Dr. Gabor Maté*

Trauma isn’t necessarily the event itself, but the response that our body, brain, and nervous system have to that event.

University of Northern Colorado (2022, June 10)

“Trauma is what happens in the absence of an empathetic witness.”

*-Peter Levine, Founder of Somatic Experiencing*

Trauma occurs when a stimulus, stress, or threat exceeds a system’s capacity to withstand it.

If the body, brain, and nervous system do not have the capacity to endure a stressor or threat, that event can leave a lasting traumatic imprint on the individual.

University of Northern Colorado (2022, June 10)

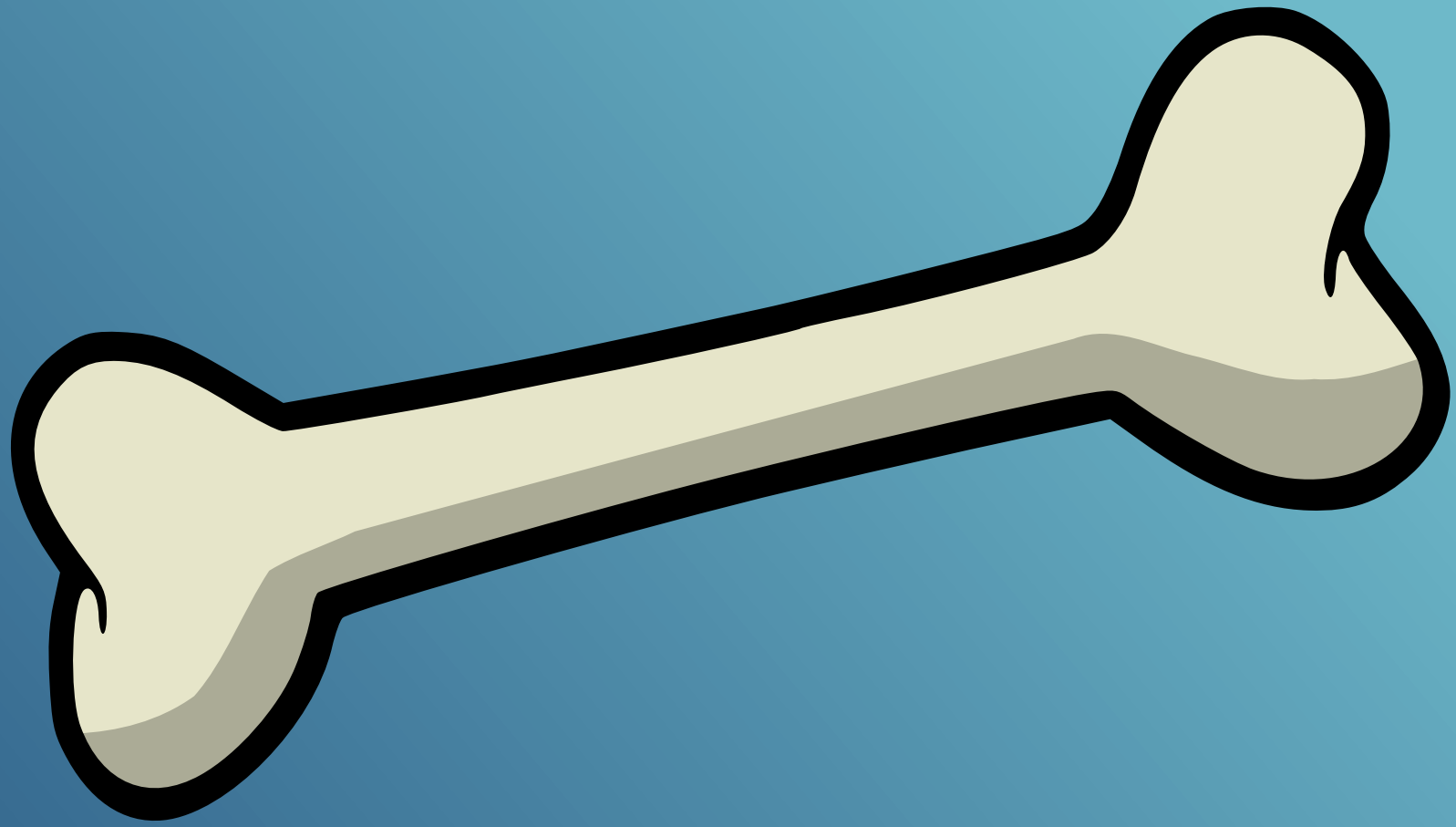
A stressor or event will not become traumatic if there was adequate capacity to handle the stimuli or if there was adequate resilience to come back to homeostasis after the threat or stress was removed.

# The way a person responds after a traumatic event depends on:

- Type and severity of the trauma
- Whether they are active or helpless
- The amount of available support following the incident
- Other current stressors (*capacity*)
- Personality and subconscious beliefs
- Natural levels of resilience
- Previous traumatic experiences

Our unique capacity to withstand or recover from a traumatic event has nothing to do with “willpower” or “mental toughness”.

Trauma can’t be “convinced” out of us with the rational, logical parts of our brain since the events impact sub-cortical brain regions and the nervous system.



- Integrity or strength
- Age
- Location of stress
- Duration of stress
- Speed
- Force
- Relaxation or tension

- Acute Trauma: Resulting from a single incident like a car accident
- Chronic Trauma: Repeated and prolonged such as domestic violence or childhood abuse
- Complex Trauma: Exposure to multiple traumatic events throughout a lifetime

American Psychological Association (2021).

- Sexual assault
- Emotional abuse
- Childhood neglect
- Serious accident or illness
- Natural disaster
- War
- Terrorism
- Domestic violence
- Life-threatening medical procedure

American Psychological Association (2021).

“I don’t understand why they can’t just get over what happened to them.”

“The way I’m responding to this right now is not rational.”

“I should be over it by now.”

“I shouldn’t be so sensitive about this.”

According to the DSM-5, *The Diagnostic and Statistical Manual of Mental Disorders*, ***trauma isn't an objectively diagnosable psychological condition*.**

PTSD, which is a formal diagnosis, often results from trauma, but ***not everyone who experiences trauma develops PTSD*.**

About 5% of Americans have PTSD in any given year.

U.S. Department of Veterans Affairs (2014)

Those who aren’t formally diagnosed can still present with various physiological, physical, and psychological changes that impact the way they think, feel, heal, connect, and behave in the world.

Authors have pointed to the diversity of trauma, suggesting that a single diagnosis of PTSD should be replaced by a variety of trauma-related disorders.

(Bovin & Marx, 2011)

# What is trauma-informed care?

# Trauma-Informed Care:

1. Understand the prevalence and impacts of trauma.
2. Acknowledge signs and symptoms of trauma.
3. Respond and support in an informed manner.
4. Aim to avoid retraumatization.

SAMHSA (2020).

There's a difference between working **on** someone's trauma, and working **with** someone's trauma.

To work **on** trauma is to tell your client what to do about it.
To work **with** trauma is to understand what they're experiencing and navigate it as it comes up.

# What might inform us that we're moving outside our scope of practice?

If we feel uncomfortable, unqualified, and unable to meet the needs of our client.

They don’t have to hold it all themselves.

Connection can be enough for us to carry on.

"It's always within our scope to be a kind person.”

# Trauma-Informed Care:

1. Doesn't involve knowing their detailed trauma history.
2. Doesn't involve assessing or even assuming trauma.
3. Doesn't involve talking about their trauma.
4. Doesn't involve treating or "healing" trauma.

SAMHSA (2020)

# Case Study

- Let’s meet Cathy.

# Case Study

- You’re a gynecologist.
- Cathy comes into your clinic and she is visibly tense and guarded.

# Case Study

- She shares she has a history of sexual abuse and that it’s been incredibly difficult for her to even book this appointment.

- How do you handle this case in a trauma-informed way?

# Self-Reflected Question

## What is a trauma-informed approach to handling a client who expresses a history of sexual trauma?

A. **Reassure her that sexual abuse happens to many people and proceed with the exam quickly to avoid prolonging her discomfort.**

B. **Tell her that her trauma is unrelated to the exam and that it's important to focus on her health. If she's still uncomfortable, offer to reschedule, but emphasize that the exam needs to happen soon.**

C. **Acknowledge her experience but minimize further conversation about it to maintain professionalism. Proceed with the appointment as planned, ensuring it's done efficiently so she can leave as soon as possible.**

D. **Acknowledge her courage in sharing and validate how difficult this experience must be. Offer to slow down the pace, explain each step of the exam before hand, and ask for consent at each stage. Let her know that she can pause or stop the exam at any time to help her regain a sense of control.**

# Self-Reflected Question

## What is a trauma-informed approach to handling a client who expresses a history of sexual trauma?

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SAMHSA (2020)

# Self-Reflected Question

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You're acknowledging what she's going through while offering appropriate accommodations within your scope. This response embodies a trauma-informed approach by prioritizing safety, autonomy, consent, and empathy, allowing the patient to feel empowered in a challenging situation.

# Trauma-Informed Care:

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3. **Respond and support in an informed manner.**
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SAMHSA (2020)

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SAMHSA (2020)

# Sweeney and Taggart, researchers and trauma survivors, define TIC as a system that:

- Understands and acknowledges the links between trauma and mental health
- Adopts a broad definition of trauma, which recognizes social and complex trauma
- Undertakes sensitive inquiry into trauma experience
- Refers individuals to evidence-based trauma-specific support
- Addresses vicarious trauma and retraumatization

(Saunders et al., 2023

# Sweeney and Taggart, researchers and trauma survivors, define TIC as a system that:

- Prioritizes trustworthiness and transparency in communication
- Seeks to establish collaborative relationships with service users
- Adopts a strength-based approach to care
- Prioritizes emotional and physical safety of service users
- Works in partnership with trauma survivors to design, deliver, and evaluate services

(Saunders et al., 2023

- **SAMSHA (Substance Abuse and Mental Health Services Administration)**
- **The UK Office for Health Improvement & Disparities**
- **The NHS Education for Scotland (NES) Knowledge and Skills Framework for Psychological Trauma**

(Saunders et al., 2023

# Trauma-Informed Principles:

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

SAMHSA (2020)

# Safety

- Creating a safe physical, physiological, and psychological environment

# Trustworthiness and Transparency

- Helping the client become informed and being a consistent safe resource for them

# Peer Support

- Being able to recognize what other sources of support a client may need (or a colleague)

# Collaboration and Mutuality

- Helping the client become an active participant in their health journey

# Empowerment, Voice, and Choice

- Encouraging a client’s autonomy and supporting them to set boundaries

# How can we advocate for our clients’ autonomy?

- “At any point, you can tell me if you don’t want to do something.”
- “Feel free to ask any questions.”
- “You’re welcome to get out of position or stop the movement at any point.”

- Do they feel safe with us?
- Do they feel like they can trust us?
- Do they feel safe to set a boundary and say no?

# Cultural Issues

- Recognizing and eliminating any racial, cultural, or gender bias to appropriately meet that client.

People in trauma often feel disempowered.

National Council for Mental Well-Being reports that trauma is a risk factor in nearly all behavioral health and substance use disorders.

How to Manage Trauma (n.d.)

Electronic health record evidence revealed that those with childhood abuse have more comorbidities and are more likely to have impatient admissions.

(Saunders et al., 2003)

When we implement trauma-informed approaches in acute, crisis, emergency, and residential health care, what outcomes can we expect?

(Saunders et al., 2003)

- Service user and staff experiences and attitudes
- Staff well-being
- Service use outcomes

(Saunders et al., 2003)

- Rates of restraint and seclusion decreased.
- Service users reported feeling trusted and cared for.
- Staff reported feeling greater empathy for service users.
- Staff reported a greater understanding of trauma.
- Staff reported needing training to deliver TIC effectively.

(Saunders et al., 2023)

# Healthcare Consideration

To implement TIC within their scope, healthcare providers should focus on creating a welcoming environment, listening without judgment, and acknowledging patients' experiences. This includes asking about trauma history sensitively, involving patients in decision-making, and adapting care to their needs, fostering trust and supporting recovery.

Staff are also affected by trauma at work and can create “reciprocal traumatization.”

(Saunders et al., 2023)

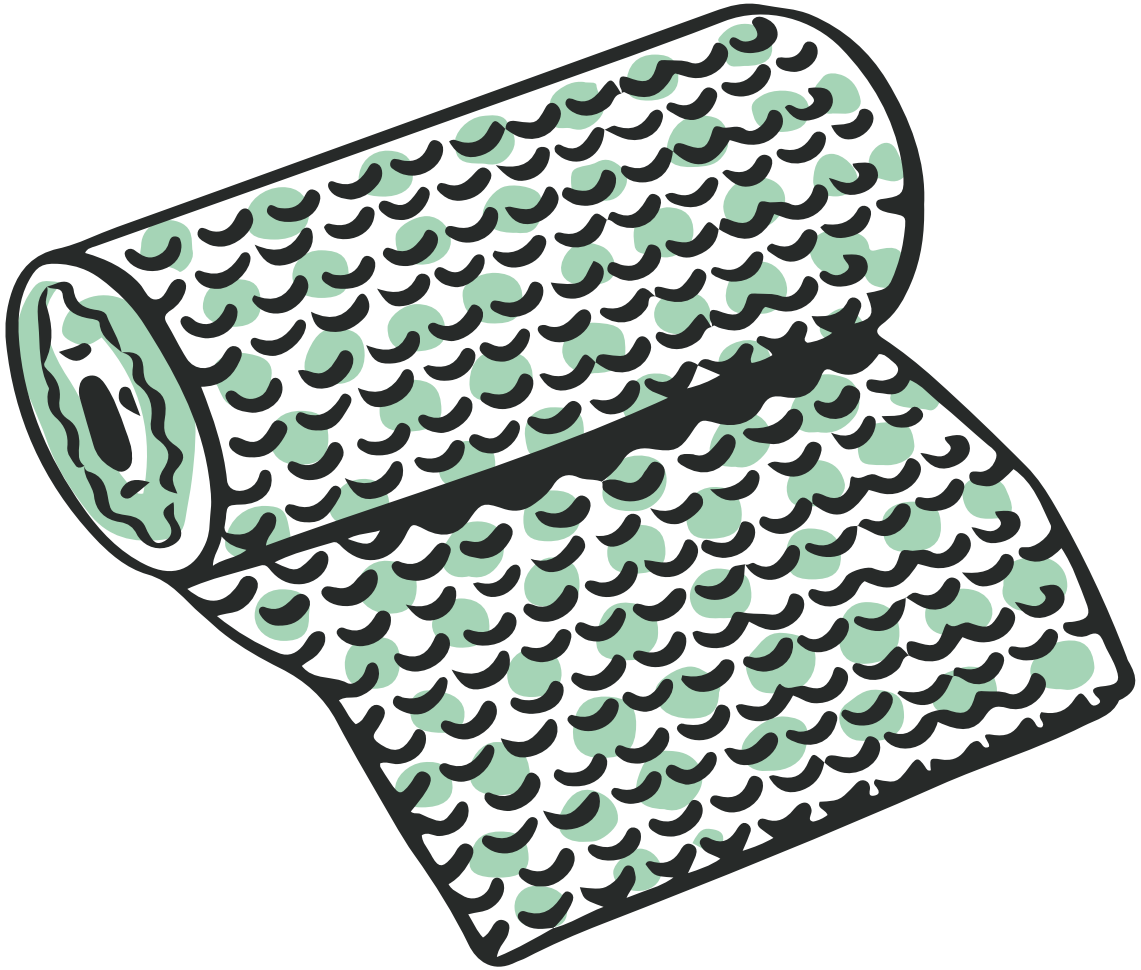
- Vicarious trauma
- Compassion fatigue
- Burnout

Compassion fatigue stems from emotional depletion due to caregiving, while vicarious trauma stems from internalizing others' traumatic experiences and experiencing a deeper impact.

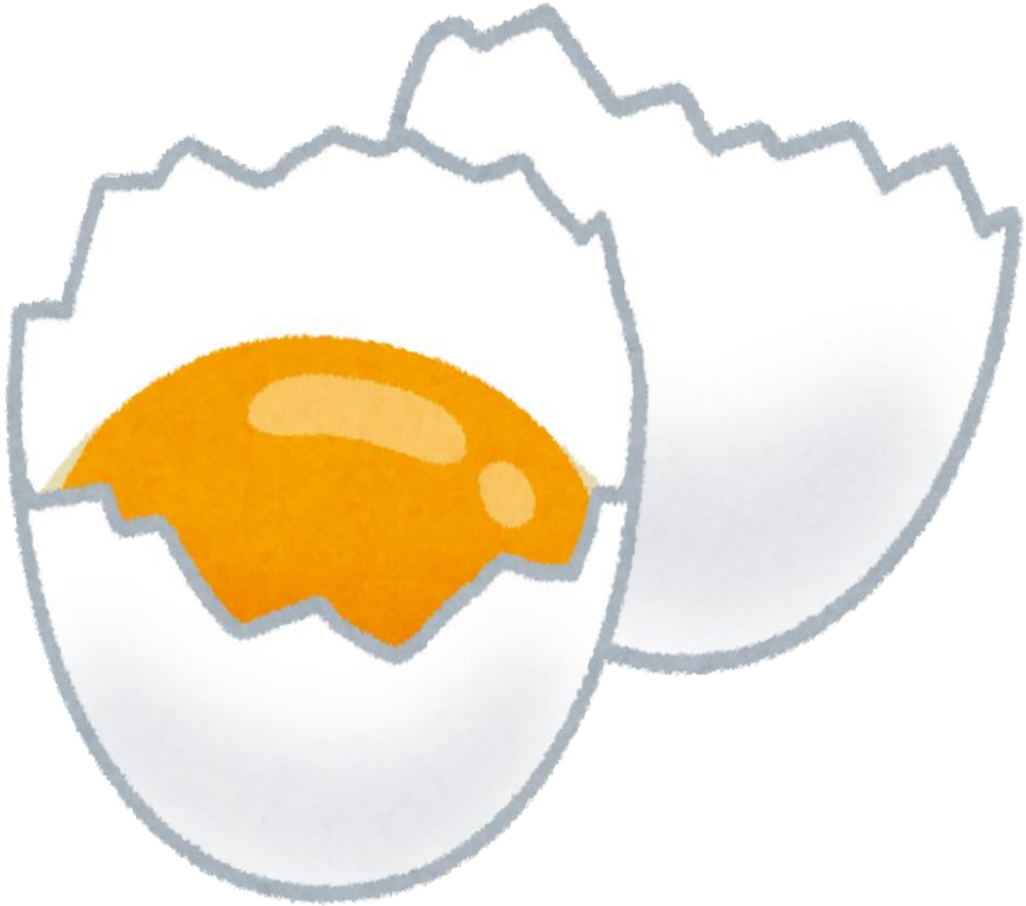
Does everybody have trauma?

Do we assume everyone has trauma?

# We do not want to bubble-wrap



# We do not want to walk around on eggshells.



How can I try to fully “meet” the human being in front of me?

When we can further understand our client’s experience, we build the trust and safety necessary for relief and healing.

# Chapter 2:
# Relationships, Touch, and the Healing Power of Connection

# Chapter 2: Relationships, Touch, and the Healing Power of Connection

- Highlighting the benefits of social connection, touch, and therapeutic relationships for those with complex trauma.

In early 2020, we experienced radical social isolation.

A study by American Perspectives reported in May 2021 that Americans reported fewer close friendships.

They spoke less often to friends and relied on them less for support.

Cox (2021, June 8)

A report by the National Academies of Sciences, Engineering, and Medicine noted that 33% of adults over 45 feel lonely, and 25% of adults over 65 are socially isolated (even without a pandemic).

Donovan & Blazer (2020)

Strong evidence points to health risks in lonely or socially isolated adults, including an **increased risk of premature death.**

Involuntary loneliness was comparable to that of smoking or being obese and physically inactive.

Cacioppo & Cacioppo (2013)

Loneliness was noted to cause an increased risk in heart disease, dementia, stroke, depression, anxiety, suicide, and emergency department visits. In numerous studies, social support has repeatedly been shown as a powerful source of protection against overwhelm and trauma.

Cacioppo & Cacioppo (2013)

“Trauma is the absence of an empathetic witness.”

*—Peter Levine, PhD*

Humans are wired with an innate fear of abandonment since for thousands of years, being cast from the collective could likely mean death.

# Hyper-independence as a Stress Response

- Difficulty trusting others
- Difficulty asking for help
- Difficulty with delegation
- Difficulty with receiving support
- Difficulty forming close or long-term relationships

Loneliness can drive heightened inflammatory and metabolic changes due to the stress of isolation.

Cacioppo & Cacioppo (2013)

There’s nothing shameful about needing each other. To resist needing one another is to resist being human.

People with trauma have often experienced a **betrayal of trust.**

*Violation*.

# How do We Build Trust?

- Follow-through.
- Apologize when you’ve made a mistake.
- Repair ruptures.
- Respect boundaries.
- Educating.
- Active listening.

# How do We Build Trust?

- Have curiosity.
- Reduce judgment.
- Be present.
- Be honest and transparent.
- Be authentic.

**We may still hurt, offend, or trigger people and that’s okay.**

# How to Apologize

- Clearly state *what you did wrong*.
- Express your remorse and understanding.
- Avoid making excuses or blaming.
- Offer to make amends and take responsibility.
- Commit to not repeating the behavior.
- Listen actively without expectations.

Corliss (2021, April 13)

# How to Apologize

- Be present in your body.
- Accept their feelings/experience.
- Remain nonjudgmental.
- Resist taking anything personally.
- “*Soak it in without taking it on*.”

Corliss (2021, April 13)

# Touch, attunement, and early childhood relating

In 1915, institutions that housed infants concluded that most died of marasmus, or “wasting away.”

These children under 2 had passed from a failure to thrive due to lack of attunement, connection, and touch. For those that did manage to survive, deprivation of touch was linked to higher levels of adult aggression and other emotional disruptions.

Howard Gray (1989)

Other bodies of research have confirmed that touch during early development boosts healthy weight gain and resilience to stress.

Dagnino-Subiabre (2022)

The pediatrician and psychoanalyst Donald Winnicott, the “father” of modern studies of attunement, studied early physical bonds between mother and baby.

He proposed that touch was so critical in development that he noted, “these physical interactions lay the groundwork for a baby’s sense of self—and, with that, a lifelong sense of identity.”

Bigelow & Williams (2020)

“*the way a mother holds her child underlies the ability to feel the body as the place where the psyche lives*.”

When a caregiver can’t consistently meet the baby’s impulses and needs, the child can become “detached” from its own sensations and shuts down feedback from their own body.

If their impulses and needs are consistently not being met, their ability to attune to themselves dampens.

For those who weren’t able to get the necessary care, attunement, touch, and connection in early life, their ability to identify their needs in adulthood may be challenging.

Bornstein & Esposito (2023)

# Exploring Childhood Trauma

Where does trust begin?

# Chapter 3:
# Attachment Theory

# Chapter 3: Attachment Theory

How our earliest attachments in life can set the stage for the relationships we have later in life.

Attachment theory is a psychological theory that explains how people form and maintain close relationships.

Attachment theory explores how our early attachments in life inform the way we attach and bond in our adult relationships.

Attachment theory also explores how early relational trauma can disrupt our ability to feel safe, connected, and open with others.

Physical, emotional, and sexual abuse or neglect in childhood were positively related to  insecure attachment styles.

Erozkan (2016)

The absence of abuse or neglect in childhood were positively related to a secure attachment style (SA).

Erozkan (2016)

Insecure attachment forms from primary caregivers who are consistently unreliable, unpredictable, and negative or dangerous to the child.

This causes the child to become hypervigilant in social environments and relationships.

Erozkan (2016)

Attachment trauma or early relational trauma forces the child to develop with an **unsafe caregiver** and has been described as “horror without resolution.”

Lahousen, Unterrainer, & Kapfhammer (2019)

With an insecure attachment style, the “fight or flight” system is upregulated and abrupt changes may occur between panicked timidity and aggressive hostility.

Lahousen, Unterrainer, & Kapfhammer (2019)

**Dissociative symptoms** can also result due to a failure to integrate trauma-related events (compartmentalization) or collapsing into the protective response of depersonalization and derealization.

Lahousen, Unterrainer, & Kapfhammer (2019)

Bowlby suggests children develop mental models of themselves and of relationships that **impact** their future relationships.

Lahousen, Unterrainer, & Kapfhammer (2019)

# Insecure Attachment Styles

- Fearful avoidant (FA)
- Anxious preoccupied (AP)
- Dismissive avoidant (DA)

At the root of these insecure attachments is a deep, often unconscious, fear of abandonment.

Lahousen, Unterrainer, & Kapfhammer (2019)

# Fearful Avoidant (FA) or Disorganized Attachment

Most extreme insecure attachment and least common, formed due to intense fear or trauma in childhood due to an erratic relationship with the primary caregiver.

Those with FA attachment styles may suffer from mental health disorders or personality disorders. “Hot and cold” temperament toward others.

Marriott & Kelley (2024)

# Case Study

- Alex, a 42-year-old man, has a history of fearful avoidant attachment. In healthcare settings, Alex often struggles with trust issues and reluctance to engage fully in the therapeutic process. Alex sought help for chronic pain and frequent gastrointestinal issues. During his first consultation with Dr. Lee, he was guarded and avoided eye contact, providing minimal information about his symptoms. He expressed skepticism about the effectiveness of treatment and was reluctant to discuss his personal history or concerns in detail.

# Case Study

- Recognizing signs of fearful avoidant attachment, Dr. Lee adopted a trauma-informed approach by creating a nonjudgmental, empathetic environment. She allowed Alex to set the pace of the conversation, gently encouraged him to share at his own comfort level, and emphasized her commitment to respecting his boundaries while building a trusting relationship.

# Self-Reflected Question

**How did Dr. Lee effectively address Alex's fearful avoidant attachment style during their consultations?**

A. She pushed Alex to share personal details to speed up the treatment process.

B. She used a directive approach to ensure Alex followed the treatment plan closely.

C. She created a nonjudgmental environment, allowed Alex to set the pace, and respected his boundaries.

D. She minimized her interaction with Alex to avoid overwhelming him.

# Self-Reflected Question

**How did Dr. Lee effectively address Alex's fearful avoidant attachment style during their consultations?**

**C. She created a nonjudgmental environment, allowed Alex to set the pace, and respected his boundaries**

# Self-Reflected Question

## How did Dr. Lee effectively address Alex's fearful avoidant attachment style during their consultations?

**C. She created a nonjudgmental environment, allowed Alex to set the pace, and respected his boundaries**

Since those with insecure attachments can distrust others, especially those with an FA attachment style, allowing the patient to set the pace and respecting their boundaries can be an optimal way to develop a healthy client-practitioner relationship.

# Anxious Preoccupied (AP)

This insecure attachment style often forms due to ongoing physical and emotional inconsistencies from a caregiver. “Will my needs get met?”

Those with an AP attachment style may be seen as “needy,” often consumed with worry, or require constant reassurance in the relationship.

Marriott & Kelley (2024)

# Case Study

- Emily, a 35-year-old woman, had a history of anxious attachment, leading to fears of abandonment and a strong need for reassurance. This attachment style influenced her interactions with healthcare providers, making her anxious and overly dependent on validation. When seeking treatment for chronic headaches and digestive issues, Emily expressed anxiety about not being taken seriously. Dr. Smith, recognizing her anxious attachment, used a trauma-informed approach by actively listening, validating her concerns, and involving her in her treatment plan. Through consistent, empathetic care, Emily began to trust Dr. Smith, her anxiety lessened, and her physical symptoms improved.

# Self-Reflected Question

**What key approach did Dr. Smith use to help Emily feel more secure and improve her healthcare outcomes?**

A. He quickly prescribed medication to address her symptoms.

B. He dismissed her concerns to focus on more pressing medical issues.

C. He actively listened, validated her concerns, and involved her in decision-making.

D. He limited the amount of time spent with her to avoid reinforcing dependency.

# Self-Reflected Question

**What key approach did Dr. Smith use to help Emily feel more secure and improve her healthcare outcomes?**

**C. He actively listened, validated her concerns, and involved her in decision-making.**

# Self-Reflected Question

**What key approach did Dr. Smith use to help Emily feel more secure and improve her healthcare outcomes?**

**C. He actively listened, validated her concerns, and involved her in decision-making.**

Individuals with anxious attachment can get activated when others pull away or dismiss their feelings. Through validation and incorporating her perspectives into the treatment plan, the patient can down-regulate, leading to a stronger client-practitioner relationship.

# Dismissive Avoidant (DA)

This insecure attachment style is formed by a lack of emotional support and connection with a caregiver. They are overly self-sufficient, emotionally guarded, and unlikely to seek emotional comfort with others.

Those with a DA attachment style will distance themselves from others when activated.

Marriott & Kelley (2024)

# Case Study

- Michael, a 50-year-old man with a dismissive avoidant attachment style, tends to minimize close relationships and rely on himself. In healthcare settings, he often downplays symptoms and avoids emotional engagement. When Michael visited Dr. Carter for recurring chest pain, he was emotionally distant and downplayed his symptoms. Dr. Carter approached Michael with respect for his autonomy, providing clear, straightforward information while gently encouraging him to consider the emotional aspects of his health.

# Case Study

- Over time, Michael became more engaged in his care, acknowledging the need to address both physical and emotional well-being. Dr. Carter’s balanced approach helped build trust, allowing Michael to feel more comfortable and invested in his treatment.

# Self-Reflected Question

**How did Dr. Carter effectively manage Michael’s dismissive avoidant attachment style during their consultations?**

A. He insisted that Michael discuss his emotions in detail.

B. He focused solely on the physical symptoms, ignoring any emotional factors.

C. He frequently pushed Michael to open up about his past relationships.

D. He respected Michael's need for autonomy and provided clear, straightforward information.

# Self-Reflected Question

**How did Dr. Carter effectively manage Michael’s dismissive avoidant attachment style during their consultations?**

**D. He respected Michael's need for autonomy and provided clear, straightforward information.**

# Self-Reflected Question

## How did Dr. Carter effectively manage Michael’s dismissive avoidant attachment style during their consultations?

**D. He respected Michael's need for autonomy and provided clear, straightforward information.**

Those with a DA attachment style will come across as very self-reliant and logical. By respecting their autonomy and being clear and direct in communication, we can foster a stronger client-practitioner relationship with those living with this attachment style.

# Secure Attachment (SA)

It’s estimated that most adults are securely attached, formed by caregivers who consistently met their physical and emotional needs in infancy and childhood.

Those with a secure attachment will confidently seek out healthy and long-lasting relationships with greater trust and emotional availability.

Marriott & Kelley (2024)

# Healthcare Consideration

Early relational trauma can manifest in various ways throughout a patient's life such as difficulties in forming and maintaining relationships, heightened anxiety, emotional dysregulation, and physical manifestations like chronic pain. Healthcare providers should be aware that these symptoms may not always be directly linked to trauma and can present as general health complaints or behavioral issues. Best practices involve recognizing these signs, approaching patients with empathy, and considering their relational history when developing care plans, all while maintaining professional boundaries and referring to specialists when needed.

**What do we do when *we* are triggered?**

# The importance of somatic exercises.

“Somatics is the language of what it is to be alive and to be in a body.”

Somatic practices provide the opportunity to be mindful of what’s actually happening in the present.

# Insecure Attachment Styles

- Somatic work is being the observer.
- What am I noticing, and how do I notice that?
- Presence and perspective

Somatic exercises provide a new anchor to safety.

# Evidence-Based Practice: Mindfulness

Research has demonstrated that meditation-based tools such as meditation using focused attention, mindfulness-based stress reduction, and mindfulness-based cognitive therapy have been shown to lower anxiety, minimize symptoms of PTSD, and reduce depression, blood pressure, cortisol levels, and stress markers (Behan, 2020).

# Exercise

- Grounding Meditation

(Behan, 2020)

# Evidence-Based Practice: Slow Breathing Techniques

Slow breathing techniques improve the coordination between the autonomic nervous system, brain function, and psychological flexibility, connecting parasympathetic and central nervous system activities involved in emotional regulation and overall well-being. These techniques appear to favor the parasympathetic autonomic system over the sympathetic system, with this effect mediated by vagal activity

(Zaccaro et al., 2018).

# Exercise

- Parasympathetic Breath Cycles

Zaccaro et al. (2018)

# Healthcare Consideration

Best practices for healthcare providers include guiding clients through somatic exercises, such as grounding and breathwork, to help them connect with their bodies and regulate their nervous system. This approach not only builds trust but also strengthens the client-practitioner relationship by promoting a deeper sense of connection and safety.

Your **breath** is the anchor.

"*It is the ethical thing to do*."

# Seven Principles of Breathing

1. **Pathway**
   - Inhale through nose exhale through mouth or nose.

2. **Leading**
   - Let your breath lead your movement.

3. **Sufficiency**
   - Use only as much breath as you need.

4. **Continuity**
   - Keep breathing.

# Seven Principles of Breathing

5. **Pendulum**
    - Let the breath naturally finish a full cycle.

6. **Independence**
    - Your inhale or exhale aren't tied to a specific phase of a movement or activity.

7. **No tension**
    - Keep your muscles and body relaxed.

Explore how deeply you can inhale and exhale without tension. Move like you are carrying nothing.

When we’re relaxed, we see more options.

“When you stop breathing, you are punishing yourself.”

—*Vladimir Vasiliev*

# Chapter 4:
# Safe Connection Through Co-Regulation

# Chapter 4: Safe Connection Through Co-Regulation

Learn the science behind “good bedside manner” by exploring co-regulation and its importance to a client’s success.

When we are born into this world, we are both innately resilient and incredibly vulnerable.

The critical development years from age 0 to age 6 (and even earlier in the womb) require adequate care, attunement, and nourishment from caregiver(s).

Bornstein & Esposito (2023)

With early childhood trauma, our perception of the world and our capacity for health and well-being can become altered.

Some individuals have never experienced the feeling of true safety with one another.

Bornstein & Esposito (2023)

- When we are born into the world, we are wired to attach immediately to our primary caregiver.

- In our first few breaths, we are looking to co-regulate.

- **Co-regulation** has been described as “one nervous system recognizing another nervous system.”

Bornstein & Esposito (2023)

Co-regulation operates at a biological (hormonal and nervous system) and behavioral (affective and cognitive) level.

The parent-child relationship is our first experience of co-regulation.

Bornstein & Esposito (2023)

Bidirectionality, coaction, coherence, concordance, contingency, coordination, covariation, harmony, matching, mirroring, mutuality, reciprocity, responsiveness, and synchrony

The capacity for **self-regulation** comes from consistent co-regulation in the child-parent relationship.

Bornstein & Esposito (2023)

In the 1970s, there was an experimental study done to explore the impact of attunement from our caregivers with a toddler and a mother. This study was called the “still face paradigm.”

Tronick (2016)

In the mid-1960s, another observational study took place on how emotional neglect, or the absence of consistent co-regulation in early childhood, compromises development. The researchers gathered babies aged 7-18 months from either institutional settings or loving homes to study differences in behavior.

Thousands of experiences shape us, forming an internal map of our world and others.

We unconsciously take in input to inform us what is safe, what brings us pleasure, or what repulses us, even if we have no conscious understanding as to why.

As Thomas Lewis, author of A General Theory of Love, puts it, “an individual does not direct all of his own functions. A second person transmits regulatory information that can alter hormone levels, cardiovascular function, sleep rhythms, immune function and more inside the body of the first. The reciprocal process occurs simultaneously. The first person regulates the physiology of the second even as he himself is regulated.”

Lewis et al. (2001)

# What Happens when We Co-Regulate and Create a Safe Environment?

- Physiological states become regulated to promote growth and restoration (homeostasis or “ventral state”).
- Myelinated **vagal** motor pathways that slow the heart increase.
- The fight or flight activation of the sympathetic nervous system is inhibited.

Bornstein & Esposito (2023)

# What Happens when We Co-Regulate and Create a Safe Environment?

- It lowers the stress response system of the HPA axis and reduces inflammation through immune modulation.

- Positive social engagement behaviors increase due to integration of the myelinated vagal motor pathways and muscles of the face and head (controlling eye gaze, facial expression, listening, prosody).

Bornstein & Esposito (2023)

One of the greatest gifts you can give your client is supporting a regulated or coherent nervous system.

The opportunity for your client to attune and engage in safe co-regulation with you will profoundly influence the depth and power of your work together.

In order to help somebody regulate their nervous system in your presence, it’s important that you are regulated first.

Bornstein & Esposito (2023)

What does it mean to be regulated or have a “regulated nervous system”?

Being able to be present with more of myself and my emotions without becoming dysregulated.

Learning to be with activation without being overwhelmed and having a survival response.

I can cultivate my relationship with uncertainty.

“I can be with the ups and downs.”

Do I trust myself?

# Exploring the Autonomic Nervous System (ANS)

Your autonomic nervous system has two main divisions: the sympathetic and parasympathetic branches.

Through the lens of *polyvagal theory*, the parasympathetic nervous system splits.

Polyvagal theory, developed by Stephen Porges, is a framework that explains how our ANS regulates responses to stress, safety, and social connection.

“The science of safety.”

# Autonomic Nervous System (ANS)

Sympathetic Branch
(“’fight or flight”)

Parasympathetic Branch
(“freeze”)

Ventral Vagal

Dorsal Vagal

# The Sympathetic Branch is Associated with the “Fight or Flight” Response.

- Increased HR
- Eyes dilated
- Flushed
- Racing thoughts
- “Tunnel vision” to evaluate strategies escape or attack

Sympathetic activation gives us the ability and motivation to mobilize. It is the “mobilization” branch.

# Autonomic Nervous System (ANS)

Sympathetic Branch
(“’fight or flight”)

Parasympathetic Branch

Ventral Vagal

Dorsal Vagal

# Parasympathetic Branch

Ventral Vagal

(social engagement system)

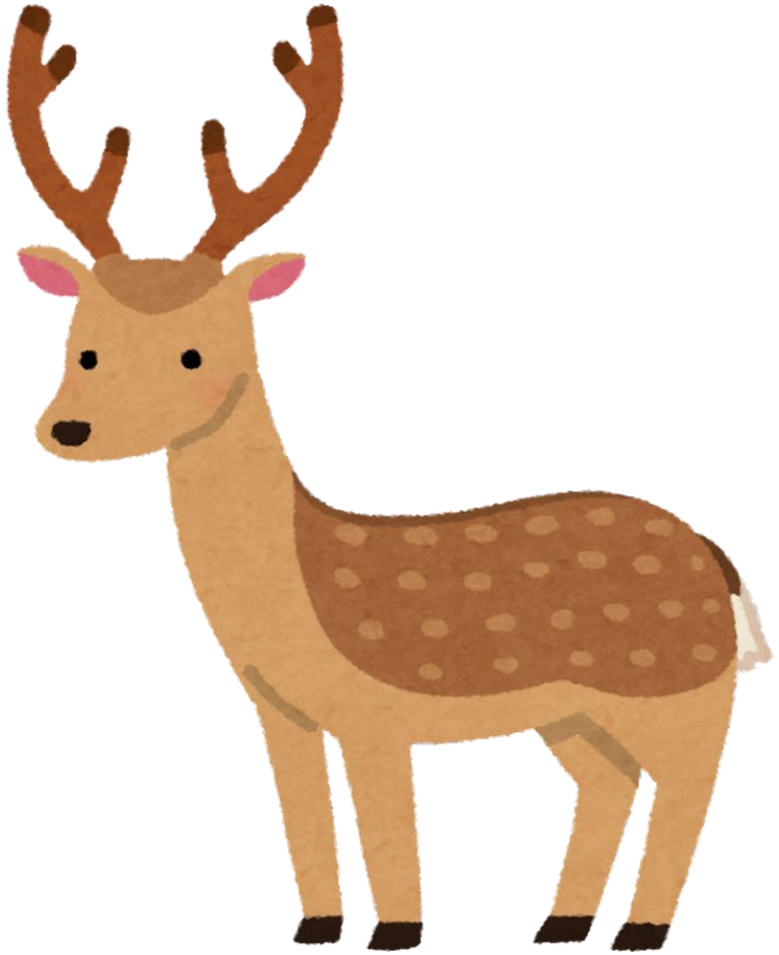
**Dorsal Vagal**

**(freeze/shut-down)**

The parasympathetic branch is associated with the “freeze” response. When fighting or fleeing proves unsuccessful, a “freeze” response is a last-ditch effort in order to survive.

Roelofs (2017)

# “Deer in headlights.”



**The freeze response is a survival solution in predator-prey dynamics.**

If the mammal stays motionless, the predator might not see them. A lack of motion can also signal illness or death.

Roelofs (2017)

If the sympathetic branch represents mobilization, the parasympathetic branch represents immobilization.

Roelofs (2017)

- Lowered heart rate
- Decreased motivation or ability to move
- The sensation of heavy limbs
- Feeling cold or numb
- Inability to think clearly
- Dissociation

Roelofs (2017)

**Dissociation** is the disruption of one or all four main areas of functioning including our consciousness, our identity, our memory, and our awareness of ourselves and our surroundings. When this occurs, we may feel detached or as if the world is unreal.

We also enter a parasympathetic state when we’re sleeping, digesting, resting, and even connecting with others.

# Parasympathetic Branch

**Ventral Vagal**

**(social engagement system)**

Dorsal Vagal

(freeze/shut-down)

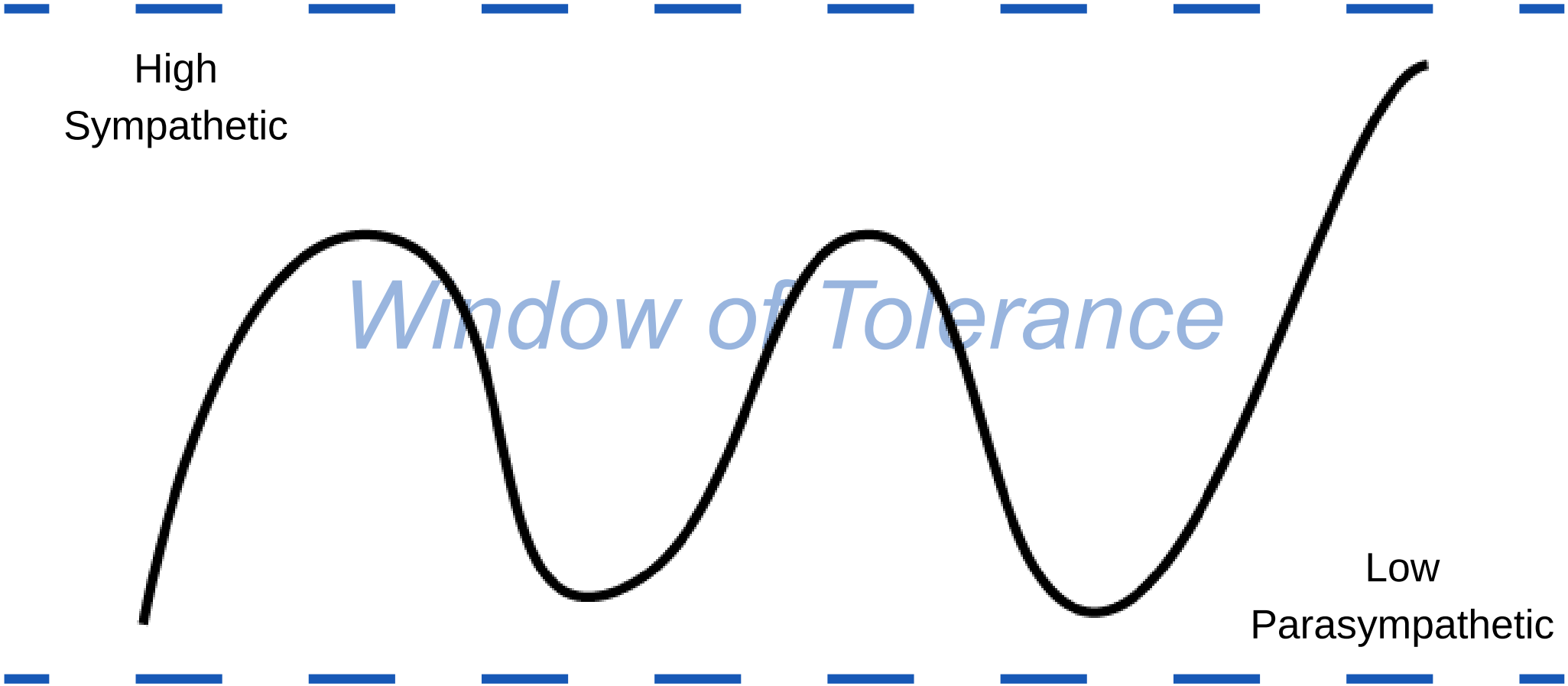
Ventral vagal is also referred to as the “social engagement system” or a “physiological state of safety.”

We feel resilient, capable, calm, present, attuned, and connected.

“It’s hard to heal in the same environment you got hurt in.”

After sympathetic arousal, there is a normal reciprocal activation of the parasympathetic branch.

Sherin & Nemeroff (2011)




Sherin & Nemeroff (2011)

# Signs that a person's ANS is in balance and at rest:

- Embodied and present with all layers of themselves
- Relaxed and at ease, but alert
- Available for connection
- Emotionally stable
- They feel like they have choices and options
- Fluid and resilient responses (physiology is appropriately responsive)

Sherin, J. E., & Nemeroff, C. B. (2011).

- **Flexibility/Fluidity**
- **Resiliency**
- **Capacity**
- Ideally these characteristics are *organic*.

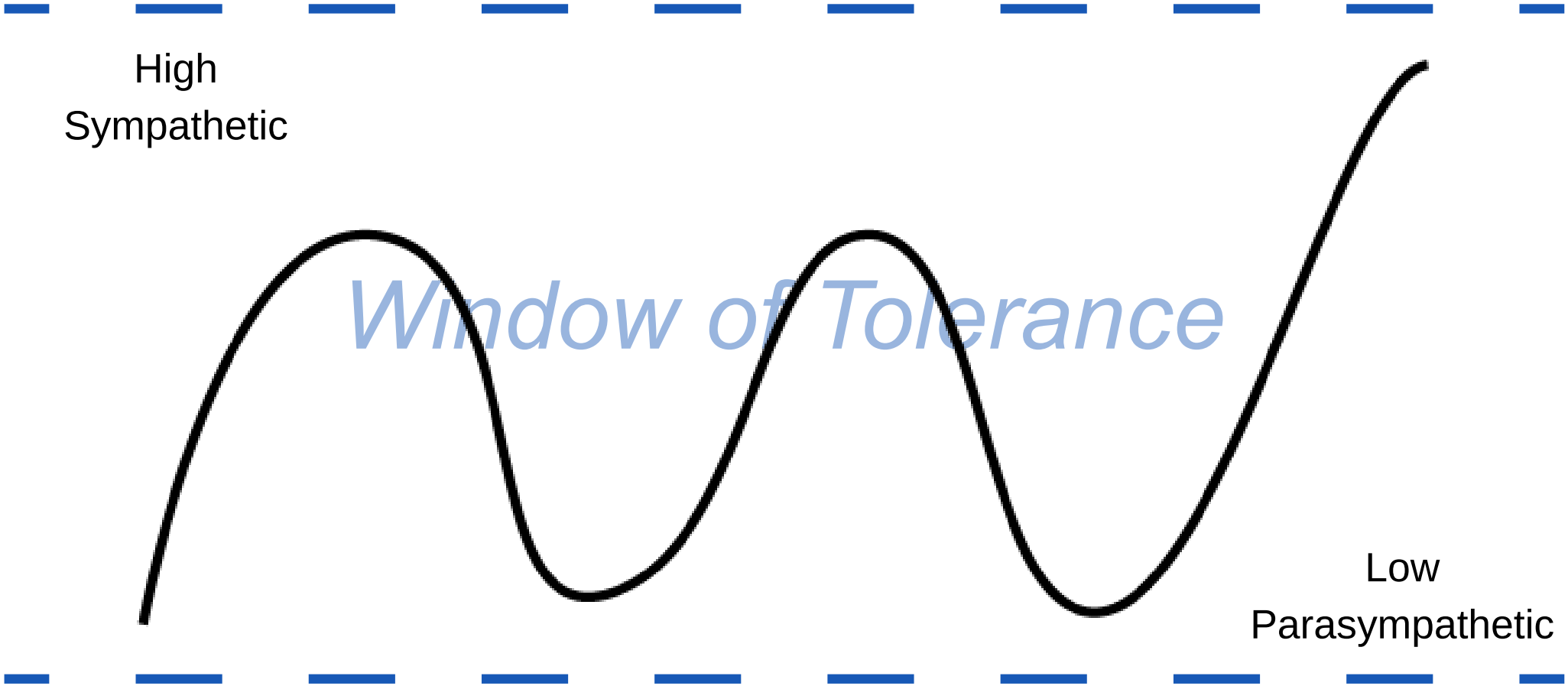
- **Flexibility/Fluidity:** Being able to move in and out of our stress states (pendulation)
- **Resiliency:** Being able to orient back to safety after a trigger/stress response
- **Capacity:** Expanding their ability/tolerance to be with the world/sensations/feelings (“it’s safe to notice”)

If a trauma/traumas occur and there isn’t a biological completion (inadequate defensive response), the system can fail to organically return back to healthy functioning, causing inappropriate responses to environmental stressors or challenges.

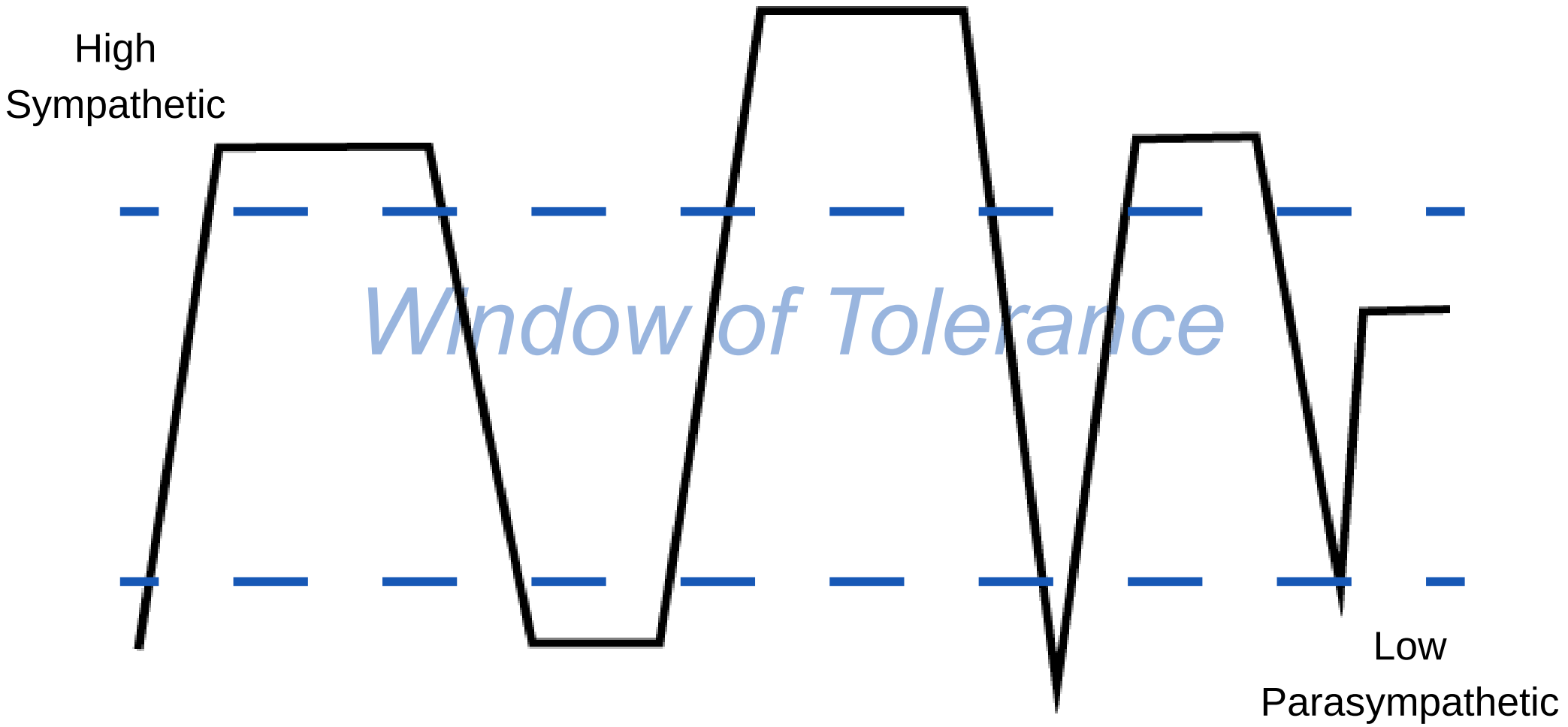
Sherin & Nemeroff (2011)

“We survived.”

Sherin & Nemeroff (2011)




Sherin & Nemeroff (2011)




Sherin & Nemeroff (2011)

Really “on” or really “off.”

Under extreme or inescapable stress, the ANS can alternate between sympathetic and parasympathetic branches.

Payne et al. (2015)

# Exercise

- State Tracking

# Autonomic Nervous System (ANS)

Sympathetic Branch
(“’fight or flight”)

Parasympathetic Branch

Ventral Vagal

Dorsal Vagal

# Exercise

- Signs of Safety

Encouraging and highlighting organic discharges of sympathetic energy.

Note for down-regulation - a sigh, a fart, a yawn, gurgling tummy, soft eye contact

Dorsal > Sympathetic > Ventral

Note for organic signs of mobilization - orientation, movement, sigh

# Exercise

- Noticing Co-regulation

# Exercise

- Encouraging Co-regulation

# Healthcare Consideration

In a clinical setting, co-regulation involves the practitioner helping clients manage their emotional and physical states through supportive presence, empathy, and attunement. Best practices include maintaining a calm and responsive demeanor, using reassuring language, and validating the client’s experiences. This can help clients feel safe and supported, which is crucial for building trust and facilitating effective therapeutic outcomes.

# Exercise

- Ventral Vagal Questions

What’s delighting you right now in your life? What do you find really enjoyable?

When was the last time you felt most like yourself?

What’s the most recent moment that made you smile?

Dana (2018)

What was the last thing you found really funny?

What were you doing the last time you were having fun?

- Track your state.
- Track their state.
- *Be* the empathetic witness.

“When you show deep empathy toward others, their defensive energy goes down, and positive energy replaces it.”

—*Stephen Covey*

- How do I convey that I trust in their inherent capacity without words or gesture?
- How can I provide loving compassion without trying to fix them?
- What part of myself do I inhabit when that occurs? What is happening internally?
- How do I convey my trust in their inherent goodness?

“I trust that you’ve got this, I trust in your body’s capacity, and I am here with you.”

# Chapter 5:
# Autonomy and Boundaries

# Chapter 5: Autonomy and Boundaries

How to support our patient’s autonomy and boundaries so they can maneuver through medical treatments without losing their voice.

Your clients may be suffering from “white coat syndrome.”

While we might not actually be wearing white coats in our practice, there still might be an inherent "hierarchy."

They might not know what to expect, if they'll "fail," if they'll end up with worse news, if they'll end up in worse pain, or if they'll feel unheard and dismissed.

They may see their doctor, therapist, trainer, coach, or even teacher as a primary authority over them. They might think the questions they have are too stupid to ask, or that they have to implement everything that this authority is saying.

One of the principles set by the American Physical Therapy Association relates to patient autonomy.

The principle states, “Physical therapists shall provide the information necessary to allow patients or their surrogates to make informed decisions about physical therapy care or participation in clinical research.”

The APTA Guide for Professional Conduct (n.d.)

As an article in Harvard Health Publishing stated, “Physicians study for years to become doctors and bring their scientific knowledge and clinical acumen to the office and the bedside. Patients may not have those skills, but they know their own bodies, tolerance for treatment, and the manner in which they are comfortable receiving care.”

Bernstein (2018, May 7)

We’ve often been taught that we’re the “leaders” in a session or treatment.

However, in a lead-follow dynamic, the “follow” is always the one ultimately leading.

This is the back-and-forth dance we engage in with our clients.

Clients may have an unconscious stress response to health professionals or medical interventions.

How can we minimize this stress response and encourage more safety and co-regulation?

What is their relationship to authority? Fawn? Fight? Flee? Freeze?

When working with a client, *collaboration* is key. When designing their program or before entering a session, explore the inquiry, “How can I support my client’s autonomy here?”

“Would you like to,” “would you be open to,” or “how about we try this?”

“Is there anything else you want to share?”

“What steps do you feel like would help you move forward the most this week?” or, “What do you feel like you need in order to move forward?”

These open-ended, self-reflective questions help the client restore empowerment in themselves.

This softens the dynamic so that we aren’t always seen as the main authority to “fix” them but rather encouraging a collaborative relationship.

# Other Ways to Support Your Client with Trauma or Chronic Stress

1. Be extremely clear about your work together.
2. Be a reliable, trustworthy person.
3. Take responsibility.
4. Repair ruptures.
5. Exercise consent.

- Consent is informed.
- Consent is voluntary (not coerced).
- Consent is revocable.
- Consent may be verbal.
- Consent may be nonverbal.

- Silence is not consent.
- Passivity is not consent.
- Consent must be freely given.

# Examples of Verbal Consent

- “Yes”
- “Let’s do more”
- “I’d like to continue”
- “I agree”
- “I would like that"

# Examples of Nonverbal Consent

- Head nod
- Thumbs up
- Increased proximity
- Nodding yes
- Direct eye contact
- Actively touching

Encouraging a client’s autonomy also means encouraging a client to set their boundaries.

“Boundaries are the distance at which I can love you and me simultaneously.”

—*Prentis Hemphill*

Boundaries are an expression of our feelings or needs.

Setting boundaries can be very challenging for those with a trauma history.

# Was Setting Boundaries Safe?

- Consequences for setting boundaries
- Rewarded or praised for not having boundaries
- Disrespect and lack of acknowledgement for boundaries
- Shame, guilt, or manipulation used when setting boundaries

# Subconscious Beliefs About Setting Boundaries

- “I don’t deserve to set boundaries or have my needs met.” (I’m not worthy/I don’t matter)
- “I’ll be rejected or hurt if I set boundaries.”
- “I won’t be loved if I set boundaries.” (Identity formed around self-sacrifice)

Boundary setting is the art of taking oneself into consideration.

In a therapeutic setting, our client’s ability to take themselves into consideration is paramount to their healing.

# Boundaries need space to exist and be shared.

- “What do you need?”
- “How do you feel about that exercise/protocol/solution?”
- “Is there anything else you’d like to add?”
- “I’d love if you shared your thoughts.”
- “Your input matters to me.”

# Boundaries need space to exist and be shared.

- Try leaving a few minutes at the end of a session to discuss any hesitations or problems they might have, while letting them know on the front end what your time boundary is.

Encourage your client to identify what their boundaries might be ahead of time when they’re nervous about seeing other health professionals.

Some clients don’t know that they can refuse treatment, or parts of a treatment. While there may be repercussions to refusal that they will be responsible for absorbing, knowing that they have the option to opt out (or ask for other options) can be relieving.

- Give them a safe, open space to speak.
- Validate their fears around setting them.
- Help them clarify their needs or boundaries.
- *The more a client is able to express their needs and boundaries, the more safe they'll feel in your care.*

# Chapter 6:
# Trauma-Informed Principles for Business and Marketing

# Chapter 6: Trauma-Informed Principles for Business and Marketing

Bringing trauma-informed care into the way we market to clients and conduct our business

We are all selling. Selling is just a conversation.

We likely all have experienced being sold to in a way that felt disingenuous, uncomfortable, or uncaring. We might have felt pushed to agree or disregarded when we brought our concerns up.

There's nothing inherently wrong or unethical about selling or marketing. Selling is a natural part of our language.

Selling is an exchange of value.

When particular "sales tactics" are used, selling becomes less like a respectful conversation and more like hard persuasion.

Many sales tactics are designed to put the potential client in a highly emotionally aroused state in order to purchase.

Reinforcement of their “pain points” or “digging in the knife”: There might be a strong emphasis on what will happen if they don't move forward, intentionally provoking more stress, fear, or anxiety in order to commit.

- Other sales tactics involve shame and guilt.

- If somebody needs more time to make a decision, many strategies involve convincing the potential client if they were serious enough, they would move forward right away.

- In some circles, there’s an emphasis on “stretching” ourselves financially in order to truly transform, which can cause people to intentionally move outside their window of tolerance in order to purchase.

Other shaming techniques involve highlighting someone’s deepest insecurities.

If somebody feels bad, wrong, ugly, unloved, or undesirable, they'll be more willing to purchase the product designed to give them relief. This is used commonly to sell fat loss supplements, beauty products, or plastic surgery.

If you have doubts about your sales strategy, consider asking yourself, “Am I being honest, up-front, and clear in the value exchange? How can I help this person feel safe in their decision-making? How do I feel in my own body when I’m selling?”

- Even if we’re coming to the sales conversation with integrity, it’s still possible that a potential client might respond through a fawn, fight, flight, or freeze response.

- They might have a fawn response and move forward with you because they feel obligated to or because they don’t want to upset you.

- They might have a fight response and get reactive over the price or proposition.
- They might have a flight response and avoid further communication.
- Or they might have a freeze response.

- In these situations, it's helpful to reassure the individual that whatever they decide to do is okay. We never know what’s actually the best decision for them.

- Allowing them the space to decide what they want with inquiry instead of pressure protects their autonomy and builds safety in the relationship. It creates the collaborative tone that will set the stage for a healthy practitioner-client dynamic down the road.

- Introducing trauma-informed principles into our marketing can help create a more congruent, safe, and inviting experience for our customers.

- Another way to simplify your sales strategy might be to ask yourself, “How would I like to be marketed or sold to? What feels safe and inviting for me?”

It’s less about what we’re doing, and more about how we’re being.

“It’s always within our scope to be a kind person.”

Jess Mather

liverehabited

hello@chronicpainandtrauma.com

**You have completed the course:**

Fostering Safety and Trust Through Trauma-Informed Practices

Thank you!