



WORKING WITH CLIENTS THAT HAVE EXPERIENCED TRAUMA

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Aims

- To provide staff working with service users with a robust toolkit with which to work with trauma
- To explain what trauma is and the different types of trauma
- To explain the impact of trauma and the potential resulting behaviours
- Provide guidelines for working with individuals impacted by trauma
- Explain the impact of trauma on services and staff and ways to manage this
- Provide a list of support services
- Provide an infographic to explain trauma response(s) to service users
- Provide a reading list for further reading

Introduction

Trauma is a significant issue for people who are experiencing homelessness; strong links have been found between homelessness and complex trauma¹. Homelessness has been named as one of the negative effects associated with adverse childhood experiences (ACEs).

ACEs include childhood abuse (physical, sexual, or emotional); family breakdown; exposure to domestic violence; or living in a household affected by substance use, mental illness, or where someone is incarcerated; and emotional and physical neglect. To find out more about ACEs watch this [video](#). A Welsh Study² found that one in 14 (7%) of the Welsh population reported lived experience of homelessness, and those who reported four or more ACEs were 16 times more likely to report lived experience of homelessness at some point in their adult lives. The study found that the more ACEs experienced in childhood, the greater the likelihood of mental health problems and physical health issues.

The experience of trauma (in early life especially) has an impact on the brain, the capacity to manage distressing emotions and the way safety and comfort is sought within relationships during stress. In short: *unhappy childhoods tend to result in unhappy adults.*

This toolkit aims to provide staff members working within the homelessness sector with information on how to recognise traumatic responses within individuals, guidance on how to work with clients who have been traumatised, and how to recognise and reduce the impact of working with trauma on oneself. This toolkit provides a comprehensive overview on trauma, including theories, *therefore **staff may wish to dip into sections that are relevant to their work with clients. Please take care of yourself while reading.***

¹ https://www.evolvehousing.org.uk/wp-content/uploads/2018/06/Evolve_Trauma_Homlessness_Report_Master_June2018.pdf

² <https://phw.nhs.wales/files/aces/voices-of-those-with-lived-experiences-of-homelessness-and-adversity-in-wales-informing-prevention-and-response-2019/>



What is trauma?

'The paradox of trauma is that it has both the power to destroy and the power to transform and resurrect' Peter A Levine

Trauma can involve a single experience, or repeated experiences, which overwhelm an individual's ability to manage or assimilate the emotions or ideas related to that experience. Traumatic events can happen at any age and can cause long-lasting harm.

Anyone can be traumatised, and everyone will be impacted by trauma in different ways. Trauma is widespread throughout the world, and it can affect all ages, socio-economic status, culture, religions, and sexual orientations. Families and communities can be traumatised by an event happening to one of more of its members, with this trauma being 'handed down' generations (e.g., generational trauma). Staff members can be traumatised after listening and witnessing the suffering of service users who have experienced trauma (vicarious trauma).

Trauma contains three commonalities:

1. It was unexpected
2. The person was unprepared
3. There was nothing the person could have done to stop the event from occurring

Traumatic events could involve (not exhaustive); bullying; disasters; intimate partner violence; complex trauma; physical abuse; early childhood traumas; refugee trauma; sexual abuse etc.

It is the individual's experience of the event that determines whether something is traumatic. Individuals may also be more resilient to trauma if for example they have a strong attachment to a caregiver and are supported after the event. Child development professionals now agree that children with attachment disorders are in fact traumatised children. If you would like to learn more about attachment styles, click [here](#).

Due to the sense of powerlessness created by traumatic events, the experience often results in the individual experiencing feelings of shame. Trauma may impact the individual's identity, resulting in negative effects of the mind, body, spirit, and soul. Survival mechanisms may include blocking the experience from their memory or trying to avoid any reminders of the trauma. If trauma is not processed then it is ever-present for the individual, and they will feel as if the trauma happened yesterday when it may have occurred months or many years since.



Types of trauma

There are numerous types of trauma - please note this list is not exhaustive.

Developmental trauma includes:

- Child abuse (sexual, physical, and psychological abuse)
- Neglect (withholding love, affection, and the necessities of life)
- Witnessing violence in the home

Interpersonal trauma

- Childhood abuse: sexual, physical, neglect, psychological, witnessing violence in the home
- Experiencing abuse as an adult, domestic violence and / or any physical or psychological violence
- Sexual assault: any unwanted sexual contact
- Historical trauma: forcible removal from the family home, destruction of culture and language
- Loss due to homicide
- Torture and forcible confinement
- LGBT abuse and bullying
- Elder abuse: physical, sexual, financial, spiritual, cultural, psychological

External trauma

- War: combat, killing, fear of being killed, witnessing death and extreme suffering, dismemberment, having to flee your home/ country
- Being the victim of a crime
- Sudden death of a loved one
- Suicidal loss
- Loss of a loved one to homicide
- Sudden and unexpected loss of a job, housing, relationship
- Living in extreme poverty
- Natural disasters
- Accidents, vehicle, plane, etc

Trauma can result in changes to the brain, compromised immune systems, increased physical and mental stress, decreased trust, attachment difficulties and conflictual relationships, hyper-arousal, hypervigilance, rigid or chaotic behaviour.



PTSD

Post-traumatic stress disorder (PTSD) is an anxiety disorder caused by very stressful or frightening events. This usually occurs due to an incident that occurs once, normally in adult life, typically involving unexpected, sudden shock, with the unprocessed fear for life manifesting as PTSD.

PTSD can develop in response to:

1. Events that are, or are perceived as, threatening to one's own life (e.g., physical / sexual assault, childbirth experiences, serious health problems, serious road accident)
2. Witnessing acts of violence; or
3. Hearing violence or the violent death of close associates

PTSD symptoms can develop immediately, or weeks, months, or years after the event(s).

Symptoms can include:

1. Re-experiencing the event in various sensory forms, e.g., flashbacks/nightmares
2. Avoiding reminders of the trauma
3. Chronic hyperarousal in the automatic nervous system e.g., startled response

Complex/ developmental PTSD

Complex / developmental PTSD (CPTSD) will impact individuals that experienced *chronic trauma at a young age*. CPTSD is characterised by a history of *severe, repeated, long-term trauma* that usually includes exposure to caregivers who were cruel, rejecting, inconsistent, exploitative, unresponsive, or violent.

Given that children are completely dependent on the adults in their lives for survival, trauma that occurs at this stage of life deeply impacts identity and shapes beliefs about our sense of self and the world. If our care giver treats us badly, we will believe it is ourselves at fault and that there is something wrong with us – it is much scarier for children to believe their care givers are bad, and much safer to assume it is ourselves whom is at fault. Developmental trauma can therefore result in lifelong challenges for the child that experienced it.

Although CPTSD can cause similar symptoms to PTSD, people with CPTSD will most likely demonstrate additional difficulties:

- An inability to regulate their emotions and self-soothe.
- Individuals often become quite fragmented, and 'split' to compartmentalise their experience. They may also dissociate.
- Chronic feelings of guilt and shame
- Interpersonal difficulties such as not being able to trust or feel intimate with others
- Somatisation: the problem of feeling bodily symptoms for which no medical explanations can be found



- The experience of repeated trauma from a care giver creates havoc for the attachment and soothing system, creating an approach (attachment system) & avoid (threat system)
- People blame themselves and struggle to turn to others for help

You may notice that the difficulties listed above are similar to the difficulties experienced by someone with a personality disorder diagnosis. In fact, personality disorders are prevalent in individuals that have experienced chronic trauma. Studies have found that many people diagnosed with borderline personality disorder were abused as children (30-92%) depending on the study.

It is important to note that the body will remember what the mind cannot. A recent finding is that; the younger the child when trauma occurred, the less likely they will have had the ability to process what has happened to them. Therefore, the individual may not be able to process their trauma and may dissociate to survive. To learn more about dissociation watch a video created by survivors at: <https://youtu.be/UvhtDZ7G6jI>

All the symptoms someone may experience because of trauma can be understood as the individual's way of adapting to deal with the overwhelming feelings associated with a traumatic event.

The impact of trauma on the nervous system

All children require a safe, attentive, and nurturing adult relationship to develop the key areas of the brain that are responsible for managing our emotions. Without the availability of a safe attachment figure, children can develop an **overactive threat-response** system and an **underdeveloped self-soothing system**.

The body's reaction to trauma sets up several changes in the brain. When we sense danger, the limbic system (midbrain, above the brain stem) goes into action and the adrenal glands release stress hormones (cortisol, adrenaline). These hormones get us ready for a fast response (very useful in caveman times when it was needed to run away from a tiger etc). When the crisis is over, the body eliminates the stress hormone, and we go back to normal. However, **if trauma occurs early in life and lasts a long time, the effects are more persistent, and it is not as easy to 'go back to normal' after a stressful event. The limbic system is primed to stay on alert (over active threat-response system), stress hormones are chronically activated becoming toxic to the brain** (toxic stress, video [here](#)), interfering with the ability to learn new things and remember what we have learned. With their alarm system stuck on 'alert', people impacted by trauma startle more easily, have trouble accurately reading faces and social cues, have difficulty sleeping and tend to avoid situations that increase stress.

The hippocampus (part of the limbic system which is involved in organising memories) is smaller in people who have experienced long-term trauma. This is because cortisol (the



stress hormone) causes cell death in the hippocampus. This means problem solving can be difficult as well as thinking things can be better (**underdeveloped self-soothing system**).

One useful way to help individuals affected by trauma is to help them to develop their self-soothing system (see page 10 & 11 in this toolkit on suggestions on how to develop self-soothing).

Fight, flight, freeze or flop

Some individuals respond to traumatic events with a *fight* or *flight* response, whereas some people disconnect (*freeze*). If the trauma were experienced when a young child, the individual would not have been able to fight or flee (unless mentally) - these individuals therefore tend to *freeze*. People in a freeze response can become numb and dissociative and may faint. Losing consciousness is at the extreme end of the freeze response. Here is a [video](#) you can watch to learn more about fight/flight/freeze.

Appendix 1 (page 16) provides a diagram that explains how some individuals respond to traumatic events via fight/flight/ freeze/fawn. This can be given to clients to help explain why they may be responding in certain ways in response to stressful events.

It is very important to remember that people are resilient and can adapt and change – it is not all doom and gloom for people that have experienced trauma.

Window of tolerance

The ***window of tolerance*** is a term to describe ***the zone of arousal in which a person can function most effectively***. When an individual is within this zone, they are typically able to readily receive, process and integrate information and otherwise respond effectively to the demands of everyday life.

Complex trauma, or a traumatic experience, can narrow a service user's window of tolerance ***leading to states of either hyper or hypo-arousal***. It is in these two states that the individual is not able to function as effectively. Hyper-arousal tends to lead to fight/flight states of anxiety with hypo-arousal resulting in the individual freezing or going numb. It is more common for people impacted by trauma to bounce between ***hyper-arousal*** and ***hypo-arousal***.

This [video](#) provides an explanation of the window of tolerance alongside ways to help increase an individual's presence in the window of tolerance.

Appendix 2 (page 17) provides a diagram that can be used to inform service users how trauma can impact their window of tolerance.



Co-occurring disorders

Substance use is very common amongst individuals who have experienced trauma as it is a quick way to numb feelings and avoid profound emotional pain and suffering. It has been suggested that ***addiction is an attempt to solve the problem, escape suffering, and is a most effective coping strategy.*** You can watch Gabor Mate's video [here](#).

When substance use is present, any assessment surrounding mental health should consider any existing traumatic impacts. The two issues are so closely interwoven – that if the person were not dealing with trauma, they would not feel the need to use substances to cope. If the root cause of substance use is not addressed, people will continue to use substances to manage the pain and feelings associated with the trauma.

It is important to let people affected by trauma know that it is normal to use substances to cope with the overwhelming emotions and remind them that help exists for reducing or stopping substance use and for addressing the trauma.

However, trauma issues cannot be solved by sobriety alone – so when working with a service user who would like to abstain from substance use, please consider interventions that can be put in place to support them (see page 10 & 11 for suggestions/ explanations).

Guidelines for working with people affected by trauma

“If you want to improve the world, start by making people feel safer” Stephen Porges

- You will not need to know someone has experienced trauma to witness their responses and understand they have experienced trauma. If you remind yourself of the symptoms of complex trauma (page 5 & 6), we can see that an inability to regulate emotions can be a symptom of trauma. Therefore, ***explosive anger may be a symptom of trauma. Mistrust may also be a symptom*** – consequently clients may come across as suspicious and sometimes paranoid (although it is best for staff to consider this as *‘realistic paranoia’*). Clients will expect mistreatment and exploitation, and therefore may be surprised and apprehensive when treated with respect and kindness. Staff should take care to notice their own responses to client's challenging behaviour – for instance if a client becomes angry and aggressive, staff may unwittingly shout back.
- Clients may show simultaneous signs of withdrawal and excessive self-sufficiency (a 'dismissive' or detached attachment style), neediness and dependency (an anxious attachment style), or both (a 'disorganised' attachment style). This may mean ***service users are either very demanding of support workers care (worrying we will leave them) or go the other way and reject any support from staff or disengage with services.***
- To provide a safe space for clients, staff should be sensitive to the needs of client and: ***be consistent, reliable and use strong boundaries.*** Staff should expect separation anxiety



when away from work for a few days or annual leave. One way to mitigate this could be to leave a written note for clients who need reassurance when you go on annual leave. Expect a client will be upset if you are 5 minutes late to meet with them, apologise and explain why you were late.

- **Individuals cannot think/ self soothe when they are experiencing extreme emotion** – do not ask anyone to ‘calm down’ when they are angry, de-escalate rather than confront. Help the client to calm down and then discuss what happened.
- Individuals who have experienced trauma already may see themselves as inherently weak due to their experiences and the way their body responds to the trauma. Therefore, **working from a strengths-based perspective is especially important**. View the trauma as an injury that happened to them, instead of a sickness that has resulted in the individual becoming unwell. Do not think, ‘*what is wrong with you?*’, but be curious around what has *happened* to the client. Consider what strengths clients can work with e.g., maybe they have an interest in art and could run a client workshop?
- **Be aware of how you are feeling when working with clients**. If you are in a bad mood, be aware how this may impact your expressions and tone of voice and may in turn impact clients. Try to ensure your expression is not completely blank whilst talking to clients as this can also be upsetting. Additionally, consider how much empathy you illustrate to the client. It can be extremely scary for some clients if someone illustrates empathy. Some clients will find eye contact scary and may not want you to look at them. You will need to tailor your approach to everyone and their attachment needs.
- **Re-traumatisation may take place for clients**. This is a conscious or unconscious reminder of past trauma that results in a re-experiencing of the initial trauma event. It can be triggered by a situation, an attitude or expression, or by certain environments (smells) that replicate the dynamics (loss of power/control/safety) of the original trauma. You can watch a [video](#) here on re-traumatisation. ***Clients may not realise their present intense feelings are related to the past, so they may blame their present surroundings for the way they feel when there is little reason to be annoyed.***

How to speak to people who have experienced trauma

Staff working with people affected by trauma are ***advised to avoid encouraging people to talk in depth about their experiences, as this can be retraumatising for them.***

We can, however, ask people about whether they have had traumatic experiences without encouraging them to describe these events in detail. If the client wishes to talk to you about their experience in depth before it is safe for them to do so explain to them that you believe them however, it is in their best interests not to discuss it with you until they have learnt techniques to minimise any impact re-telling their story may have on them.

Conversations with individuals who have experienced trauma should be **non-judgmental and occur within a context of compassion, empathy, and humanity**. The primary focus should be



on rapport and relationship building, as well as the client's own capacity for survival and healing. Feeling rejected can be re-traumatising for a traumatised service user.

It is important to consider the following points on language and what we need to consider when working with service users affected by trauma

- Use appropriate language that matches the client's level of understanding. Consider what adaptations may be needed if English is not their first language
- Acknowledge non-verbal communication as verbal communication. Some people communicate more through behaviour than with words
- Acknowledge silence as a way of communicating. Some people cannot speak about it, or need time to feel comfortable
- Clarify anything you do not understand or are confused by. Some people will speak indirectly about trauma. For example, 'he was bothering me' could mean 'he was abusing me'
- Do not always refer to the person who abused them as 'he' and victims as 'she' or vice versa. We know that victims and those who behaved abusively can be both sexes
- Be careful about the labels 'offender,' 'perpetrator', 'batterer,' etc., because it could describe a beloved parent or family member that abused them. It is more helpful to refer to behaviour rather than characterizing a person and defining them by using a label. It is suggested to use language such as 'behaved abusively'

Skills for service users who have experienced trauma

Before suggesting that a client uses any of these techniques, you should ensure the individual has physical safety – is there anything making them feel unsafe that needs addressing before they can address feeling safe within themselves (food, shelter, physical health)? If the individual is living on the streets, it may not be safe for them to reduce their threat system as being on high alert will help to keep them safe (e.g., direct to a day centre for clients to practice these techniques while in a safe environment).

Staff should place a priority on teaching the following skills to service users to **build emotional stability and increase their window of tolerance - calming the over-active threat system**. It is also useful to help the service user understand what is happening to them in response to trauma and learn how to calm body and mind. Stabilisation skills are essential to enhance an individual's capacity to deal with everyday tasks.

Skills that can help include:

1. Psychoeducation – help them to understand what is going on for them.
2. Grounding techniques – stabilising / self-soothing techniques/ safe space visualisation
3. Breathing strategies

4. Distraction
5. Mindfulness
6. Name it to tame it
7. Self-compassion

1. Psychoeducation

Psychoeducation is very important to help individuals make sense of their trauma symptoms – e.g., provide an infographic which visually explains what is happening for them/ use what you have learnt about trauma from this toolkit to normalise their symptoms. Explain to the client all their symptoms make sense as a response to a traumatic event. Play them a video explaining the fight/flight/freeze response. There are two appendices in this toolkit (page 16 & page 17) that may be useful to refer to.

2. Grounding techniques (stabilisation/self-soothing techniques)

Grounding techniques will help to bring someone in distress back into the present moment – if you are angry, having a flash back, having a panic attack, grounding brings you back into the reality surrounding you. The more senses that can be involved in the grounding technique the better e.g., name 5 things you can see, 4 things you touch (and touch when you say them), 3 things you can hear, 2 things you can smell, 1 thing you can taste.



Other exercises include focusing on a smell that reminds you of safety – so the smell can be used to help ground when feeling unsafe. This technique can be interchanged with sound, taste, or touch as well.

Here is a [video](#) explaining an useful exercise that can be used to relax after a fight / flight / freeze response to help relax the nervous system.

3. Breathing strategies

There are numerous breathing techniques and further information on these can be found [here](#). Breathing exercises can have a great benefit to wellbeing and anxiety, e.g., gently



breathing in through your nose for 4 seconds and then breathing out through your mouth for 6-8 seconds.

Please note breathing exercises can be unhelpful if an individual dissociates when focusing on the body – e.g., feeling spaced out, mind going blank or wandering/ feeling detached/ watching yourself from outside of body). If this happens cognitive strategies and thinking about ways to navigate situations of stress would be more useful.

If breathing techniques are useful, the Breathe easy app can be downloaded on to the client's phone via their app store.

4. Distraction

Ideally distraction would include a technique that will help relaxation (listening to music/ watching TV/ go for a walk). However, when distraction is needed to help the client to avoid self-harming, the following exercises can be useful.

Hair tie on your wrist – snapping it to distract.

Rubbing ice cubes on areas of body where they might usually cut

Using a red pen to draw on areas of the body where they might usually cut

Further tips are available [here](#).

5. Mindfulness

Mindfulness is “bringing your attention back to your experience in that moment, non-judgementally”. Mindfulness groups should be run by a trainer who is experienced with working with individuals who have gone through trauma to provide alternative methods to engage with mindfulness in case any part of the practice triggers their trauma.

Further information can be found [here](#).

If mindfulness is too much, focusing on external things may help instead – e.g., watching bubbles in a drink, mindful walking,

6. Name it to tame it

Help the individual to name what emotions they are feeling – you can use a feelings wheel <https://feelingswheel.com/>

Ask the individual to name the physiological affect in the body in response to the emotion. When I get angry, my ears get hot, when I am anxious my hands get clammy. This will help them to notice their emotions earlier and implement a soothing strategy, rather than only noticing the emotion when they are overwhelmed with the emotion(s).

7. Self-compassion

Soothe your inner critic to reduce shame. Kristen Neff has several exercises [here](#).



Therapy for survivors impacted by trauma

The majority of trauma is stored in the right side of the brain making it harder to access it via cognition (via the left side of the brain) - therefore anyone traumatised probably will not be able to 'think their way out of the problem'. A client with complex trauma may not be able to engage with talking therapies, until they are able decrease their over-active threat system, (usually helped by the therapist being able to create a physically and emotionally safe environment and relationship; the reaching out to a safe trusted relationship, being the natural way most people self sooth, but unfortunately, not very available for most homeless people).

Trauma therapy includes the following:

- Dialectical Behaviour Therapy (DBT)
- Mentalization Based Therapy (MBT)
- Trauma focussed Cognitive Behavioural Therapy (CBT).
- Eye Movement Desensitization and Reprocessing therapy (EMDR).
- Body treatments including realignment, muscle release and energy healing provide an immediate change in state e.g., Sophie Dent's bodywork sessions
- Auricular acupuncture has the added advantage of reducing cravings for alcohol and drugs, as well as promoting better sleep and clearer thinking among clients who receive it regularly. It is also well suited for supporting work with refugees and immigrants in that it is nonverbal and closer to the methods of traditional medicine found in their own cultures.

Effect on service providers: Trauma exposure response and looking after yourself

It can be extremely difficult working with people who have experienced complex trauma. It will involve a lot of firefighting and may, at times, feel relentless. It is important to reflect on the possible impact on yourself of working empathetically (or not if the case maybe!) with service users impacted by trauma and reflect on ways to manage any possible impact.

Vicarious trauma is the emotional residue resulting from empathetic engagement with trauma survivors. It is secondary traumatic stress. It is suggested that you can pick this up from working with people who have been affected by trauma.

A list of possible ways working with traumatised service users may impact you are listed below:

- Feelings of helplessness (rescuer, overstepping boundaries)
- Feeling angry or despair
- We are special and the only one that can help (over responsibility)
- Feeling overwhelmed



- Feeling useless and unskilled
- Feeling the world is no longer safe
- Having no energy for self or others
- Intrusive thoughts related to events
- Numb, disconnected
- Feeling jumpy, on edge and unorganised
- Overworking, changes to smoking, drinking, eating habits
- Sleep disturbance
- Niggling physical complaints

Staff working with services users impacted by trauma will also bring their own trauma histories to work. It is known that this increases the risk of further traumatisation

Staff working closely with traumatised service users need to pay attention to how it could be impacting themselves. It is important to understand what is your 'stuff' and your client's, so you are better able to process what is happening – ensure you discuss in reflective practice. Prioritise your self-care and be alert to any re-traumatisation if your own trauma is triggered. If you experience vicarious trauma you should refer yourself for psychological support (specialised trauma counselling (EMDR/ TF-CBT), mental health first aid training, body-based therapies etc.

Please refer to the [Self-care for workers toolkit](#) for further information on what you can do to take care of yourself.

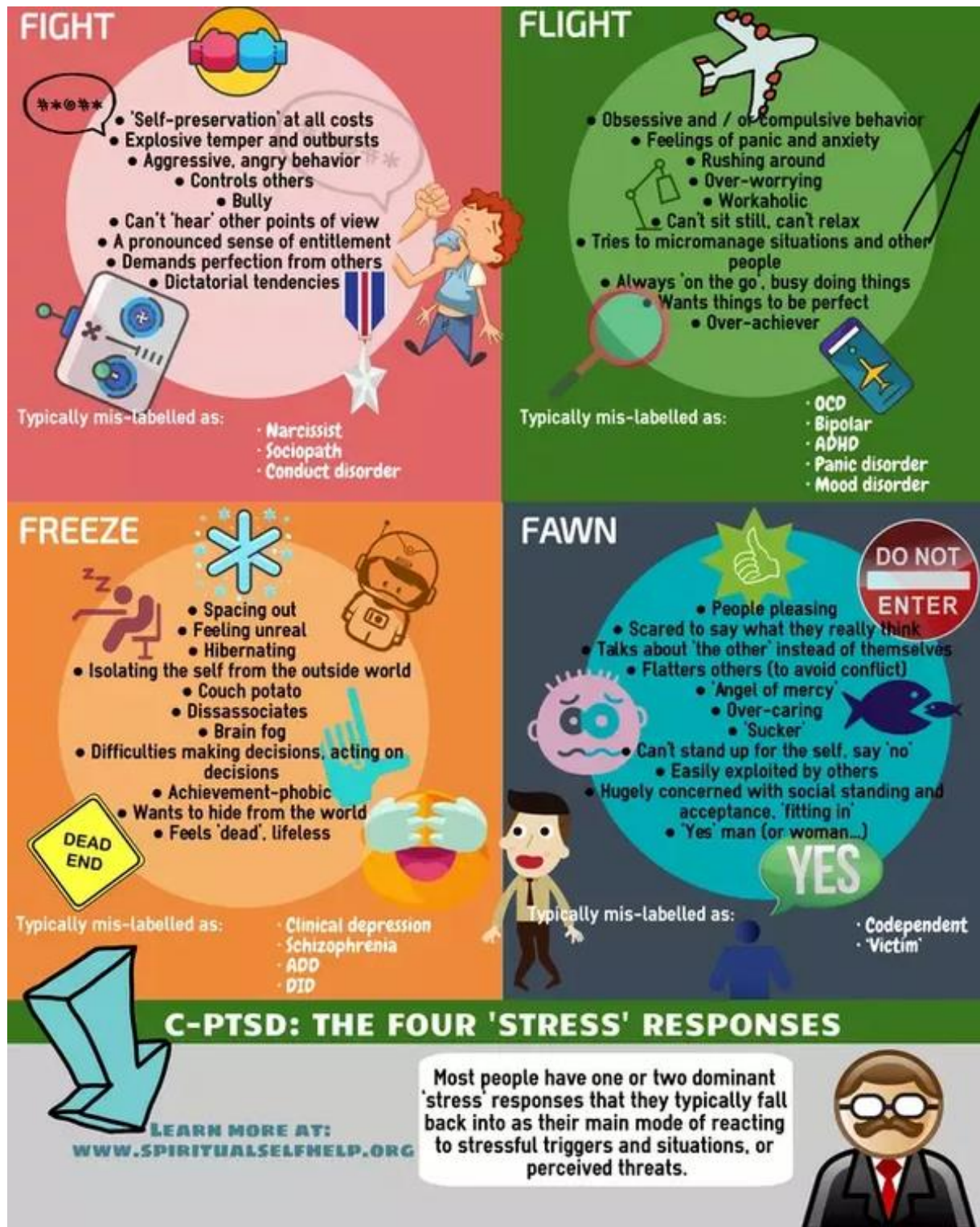


SUPPORT SERVICES

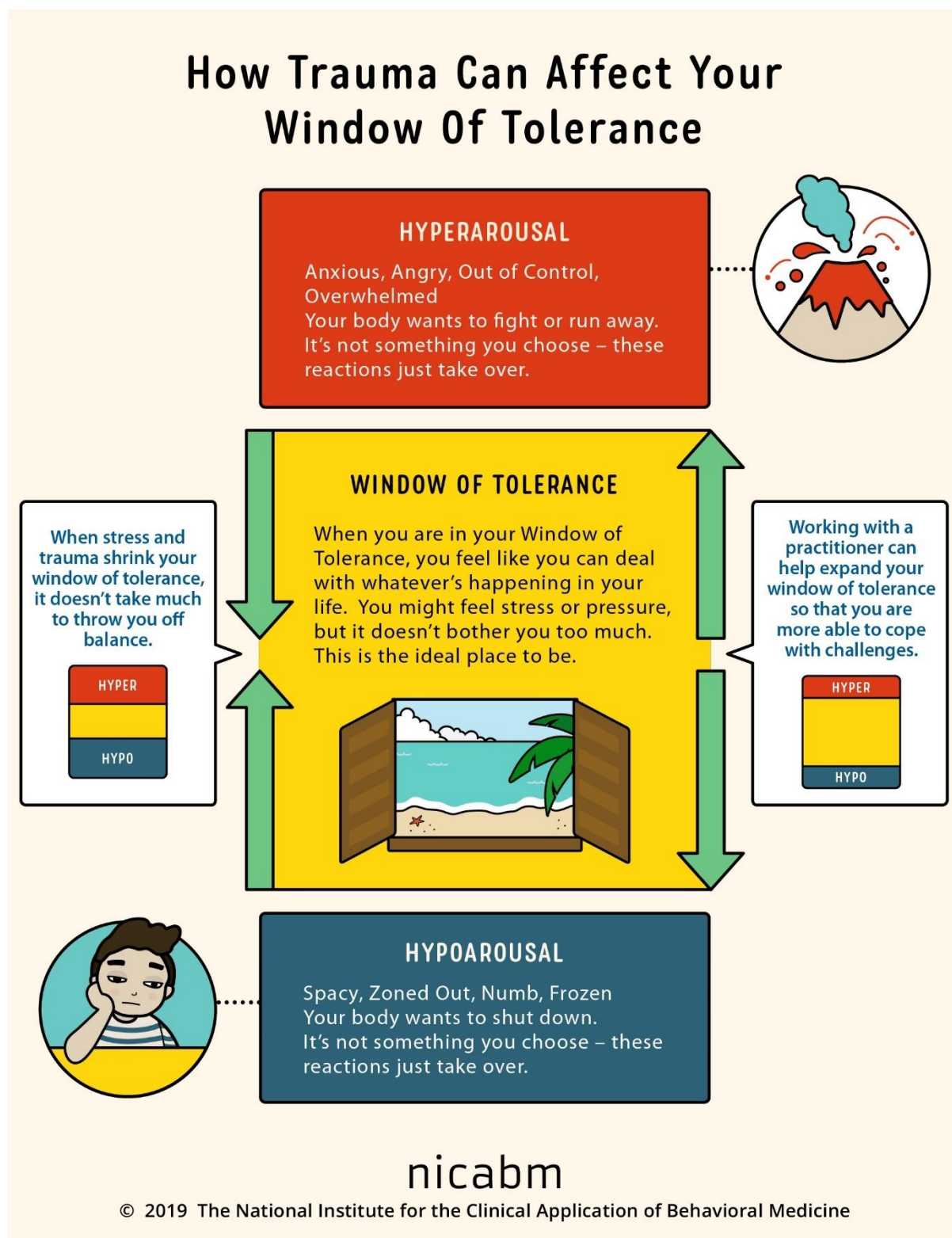


Organisation	Details
Assist Trauma Care	ASSIST Trauma Care is a specialist Third Sector (<i>Not-for-Profit</i>) Organisation offering therapeutic help to adults and children, individuals, and families, affected by a wide range of traumatic occurrences. Based at a central clinic in Rugby in the English Midlands, ASSIST therapists have been trained to use evidence-based models to help sufferers rebuild their lives and move on following a traumatic experience that has impacted them. Website: http://assisttraumacare.org.uk/our-service/ Telephone: 01788 551919
CLCH Homeless Health Counselling Service	Trauma informed – ‘drop in’ individual and/or group sessions; appointments based individual sessions up to 20 but subject to review – email: clcht.homelesshealthcounselling@nhs.net or jconolly@nhs.net
CNWL’s Traumatic Stress service	Up to 20 therapy sessions, GP or secondary care to refer via referral form at: https://www.cnwl.nhs.uk/services/mental-health-services/adult-and-older-adult/woodfield-trauma-service
Dual diagnosis service	Service users will need to be - linked in secondary mental health services (although if recently discharged then you can contact the team to see if they would consider). If not already accessing secondary dual diagnosis support, they would need to be referred to the Single Point of Access (SPA) before they would be considered. - Not taking benzos (the service cannot work with clients who are). If you would like some advice about a client who you are concerned about, please contact their care co-ordinator or SPA in the first instance.
EMDR UK and Ireland	Information about EMDR therapy and list of therapists emdrassociation.org.uk
First Person Plural	FPP specialises in working for and on behalf of all those affected by Dissociative Identity Disorder (DID) and similar complex trauma-related dissociative identity conditions. firstpersonplural.org.uk
HHCP Domestic and sexual abuse directory	https://groundswell.org.uk/westminster-hhcp/health-directories/
HHCP Mental health services directory	https://groundswell.org.uk/westminster-hhcp/health-directories/ - includes Single Point of Access and talking support (pre-treatment homeless counselling)
Mind	Mind provides advice and support to empower anyone experiencing a mental health problem. We campaign to improve services, raise awareness, and promote understanding. https://www.mind.org.uk/media-a/4149/trauma-2020.pdf
Samaritans	24 hours a day Central London Samaritans provides support for anyone experiencing feelings of distress or despair: call the helpline on: 116 123.
SINGLE POINT OF ACCESS	All referrals into CNWL adult mental health services should be made through the Single Point of Access (SPA) by telephone on 0800 0234650 or by email at cnw-tr.SPA@nhs.net

Appendix 1: Fight, flight, freeze, fawn infographic



Appendix 2: How trauma can affect window of tolerance





Additional trauma reading

- Groundswell's [Trauma action guide](#) is a useful document to provide for service users to read
- Scotland's [Trauma informed Practice Toolkit](#) for planning and developing trauma informed services.
- Carolyn Spring's '[Ways to increase window of tolerance](#)' worksheet
- MIND's trauma factsheet: <https://www.mind.org.uk/media-a/4149/trauma-2020.pdf>
- Trauma, Dissociation, and Grounding is a guide written for clients who have experienced trauma and who are troubled by dissociation. It provides clear information about dissociation and step-by-step guides to grounding: <https://www.psychologytools.com/resource/trauma-dissociation-and-grounding/>

Online training

- Aneemo's Trauma informed approaches online course <https://academy.aneemo.com/p/trauma-informed-approaches>
- Homeless Link webinar for volunteers: <https://www.homeless.org.uk/our-work/resources/webinar-catchup/basic-intro-TIC>
- Homeless Link webinar on TIC and PIE: <https://www.homeless.org.uk/connect/blogs/2016/feb/11/webinar-replay-understanding-psychologically-and-trauma-informed-practice>
- Trauma Enhanced Communication Skills - <https://www.youtube.com/watch?v=T9I1-Kkqyxc> – email iconolly@nhs.net for bespoke face to face training and role plays.

Reading

- Herman, J. (1997) Trauma and Recovery – The aftermath of violence- from domestic abuse to political terror. New York: Basic Books
- Levine, P. (1997) Waking the Tiger: Healing Trauma. California: North Atlantic Book. Trauma and the avoidant client - Robert Muller
- Rothschild, B. (2017) The Body Remembers Volume 2: Revolutionizing Trauma Treatment. New York and London: W. W. Norton & Company.
- Ogden, P. & Fisher, J. (2015) Sensorimotor Psychotherapy: Interventions for Trauma & Attachment. New York: W. W. Norton & Company
- Van Der Kolk, B. (2014) The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma. London: Penguin Books

