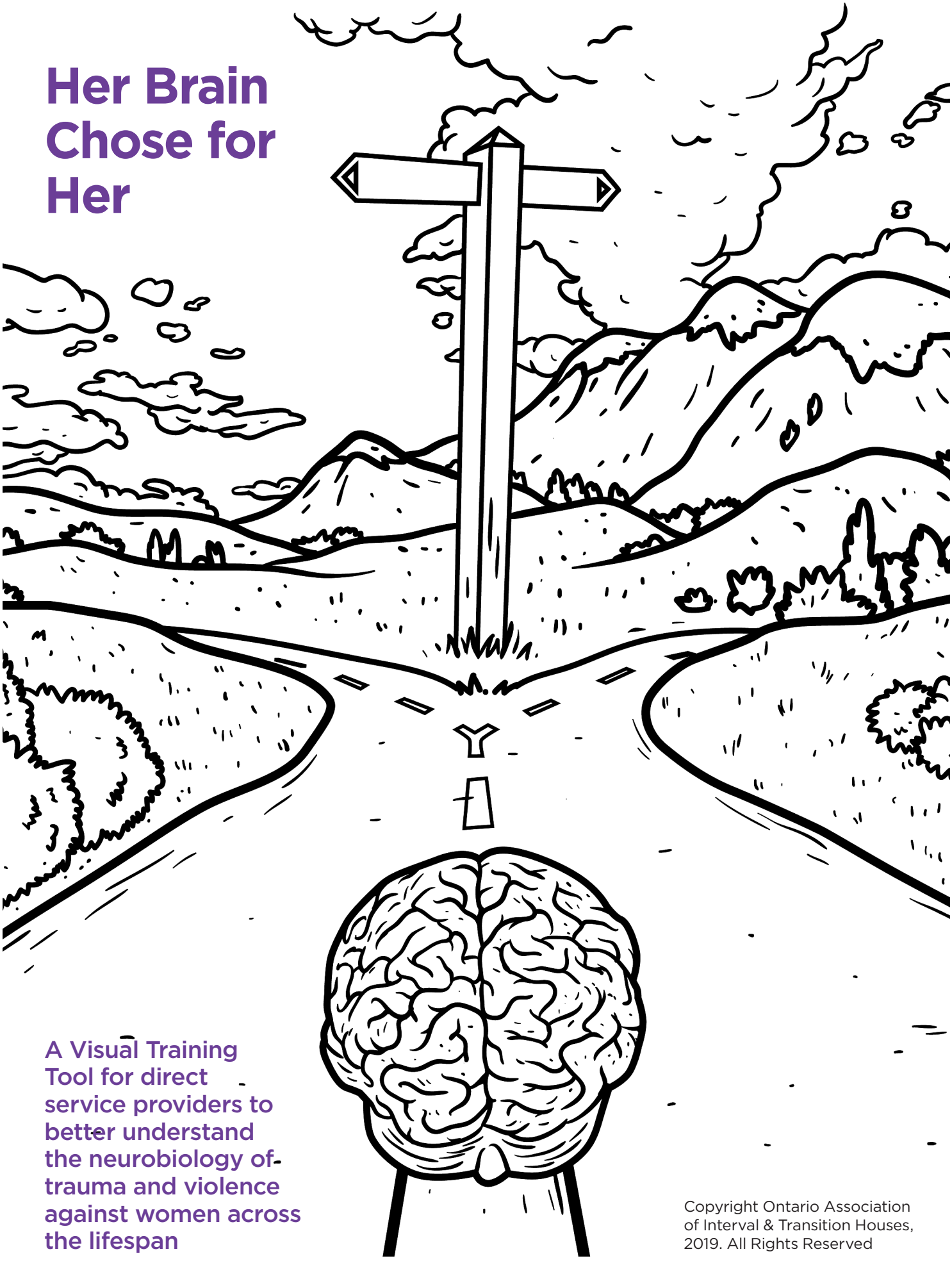

HER
BRAIN
CHOSE
FOR HER
AGING
WITHOUT
VIOLENCE.
FAITH
Ontario Association of Interval & Transition Houses

Her Brain Chose for Her



A Visual Training Tool for direct service providers to better understand the neurobiology of trauma and violence against women across the lifespan

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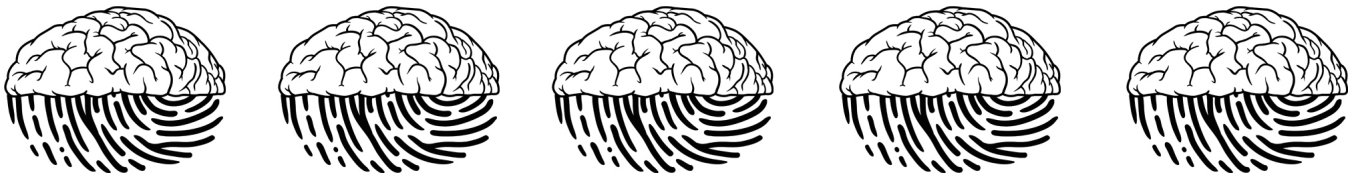
Preface
Visualizing the Invisible- Understanding Trauma-Informed Support

"Often it isn't the initiating trauma that creates seemingly insurmountable pain, but the lack of support after."

- S. Kelley Harrell



The experience of trauma fundamentally changes how a woman views herself, her world, her relationships, and her community. The effects of trauma can be longstanding and potentially debilitating, affecting problem solving ability, coping skills, feelings of loss of control, hypervigilance, sleep disturbance, intrusive memories, and flashbacks and feelings of anxiety, anger, grief, and depression.

Unfortunately, for many survivors of violence, experiences of victimization do not end with the crime as they attempt to navigate systems and services which ultimately compound the effects of the trauma she has experienced throughout her life.[1] The way any service (including healthcare, justice, violence against women, social services and age specific supports) responds to the violence a woman has experienced has a profound effect on the impacts of the trauma and resulting changes to her sense of self, trust in systems, hope for the future, and faith in a just world.

> "People who have experienced trauma are at risk of being re-traumatized in every social service and health care setting. The lack of knowledge and understanding about the impact of trauma can get in the way of services providing the most effective care and intervention. When retraumatization happens, the system has failed the individual who has experienced trauma, and this can leave them feeling misunderstood, unsupported and even blamed. It can also perpetuate a damaging cycle that prevents healing and growth. This can be prevented with basic knowledge and by considering trauma-informed language and practices."[2]

1 Hill, J. (2003). Victims' Response to Trauma and Implications for Interventions: A Selected Review and Synthesis of the Literature. Retrieved From: https://www.justice.gc.ca/eng/rp-pr/cj-jp/victim/rr03_vic2/rr03_vic2.pdf

2 Klinic Community Health Centre. Trauma-informed, The Trauma Toolkit Second Edition, 2013. Retrieved From: https://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf

Guided by a provincial advisory committee, the Aging Without Violence project (AWV) has created this Visual Training Tool (VTT) to help service providers across a wide range of sectors gain a deeper understanding of trauma-informed approaches and promising practices when working with women of all ages who have experienced violence. By visualizing the neurobiology of trauma and practices of trauma-informed care, we hope to disrupt the invisibility survivors of all ages may experience following trauma, in particular the invisibility of older women.

In understanding trauma, the AWV project advocates for a feminist intersectional analysis within a life course perspective, which recognizes the connections between types of violence and compounding impacts of violence at different stages of a woman's life.[3] When a woman's experiences of trauma and violence are only examined from one point in her life, the impacts of her previous experiences are ignored, as are potential long-term health outcomes, including reduced life expectancy.[4]

Trauma-informed approaches have the capacity to improve the experiences of survivors of violence within healthcare, justice, social services and violence against women sectors and end cycles of re-victimization while engaging women who have long been at the margins of service including those who are older, 2SLGBTQ, racialized and differently-abled.

VTT Learning Objectives

This tool is designed to increase the capacity of the user to provide trauma-informed support to women of all ages by developing a working knowledge of the neurobiology of trauma including:

- Understanding synaptic activity, neurotransmitters, nervous system responses, and brain structures associated with stress and trauma beyond flight and fight mode;
- How traumatic events impact an individual's emotions and behaviour;
- How the brain processes and recalls traumatic events and how to best provide support;
- The developing brain, adverse childhood experiences, intergenerational trauma, and options for healing;
- Using an intersectional lens when providing trauma-informed care;

3 Williams, L. (2003). Understanding Child Abuse and Violence Against Women: A Life Course Perspective. Journal of Interpersonal Violence. Journal of Interpersonal Violence, 18(4), 441–451. Retrieved From: https://doi.org/10.1177/0886260502250842

4 Etherington, N. and Baker, L. (2017). Links between the Maltreatment of Girls and Later Victimization or Use of Violence. London, Ontario: Centre for Research & Education on Violence Against Women & Children. Retrieved From: http://www.vawlearningnetwork.ca/links-between-maltreatment-girls-and-later-victimization-or-use-violence)

- The implications of complex trauma across a woman's lifespan and trauma-informed approaches specific to the needs of older women;

- Possible pathways to healing, recovery, and resilience for survivors of violence;

- Language, approaches, and techniques which may be helpful in providing service, care and support to women who have experienced trauma;

- The importance of contextualizing trauma within the oppression of social groups and the impact of sexism, classism, racism, ableism, homophobia, and transphobia on experiences and impacts of trauma from individuals and larger systems.

By understanding the connections between various forms trauma, vicarious trauma, behaviours and impacts including long term health outcomes, we can ensure when women of all ages who have experienced violence reach out, they are met with competent, informed, and effective support and access to justice.[5]

On behalf of the Aging Without Violence Provincial Advisory Committee, we hope this Visual Training Tool helps you to provide effective, trauma-informed care and support to women of all ages, understanding of just how often, experiences of fear and trauma, "her brain chose for her."

Amber Wardell
Aging Without Violence Project Coordinator
Ontario Association of Interval and Transition Houses

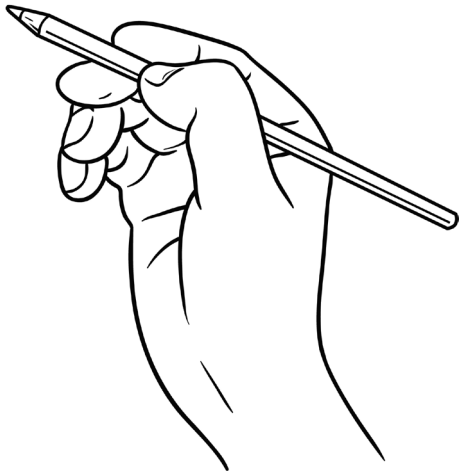
5 Ponic, P et al. Trauma- (and Violence-) Informed Approaches to Supporting Victims of Violence: Policy and Practice Considerations. Victims of Crim Research Digest No. 9. Retrieved From: https://www.justice.gc.ca/eng/rp-pr/cj-jp/victim/rd9-rr9/p2.html

Pre-Test Instructions

Before beginning this training tool, please take 5-10 minutes to complete a pre-test through the OAITH learning portal here:

Following completion of the tool, which we recommend spacing out over several weeks, you will be prompted to complete a post-test which will help us to determine how effectively the tool increases your knowledge and service capacity.

Completing This Tool



This interactive workbook contains black and white illustrations which are designed to be coloured in by the learner using felt tip markers or pencil crayons. The colouring exercises, video links and discussion and/or reflection questions will assist the reader in visualizing the neurobiology of trauma.

Project Background Information

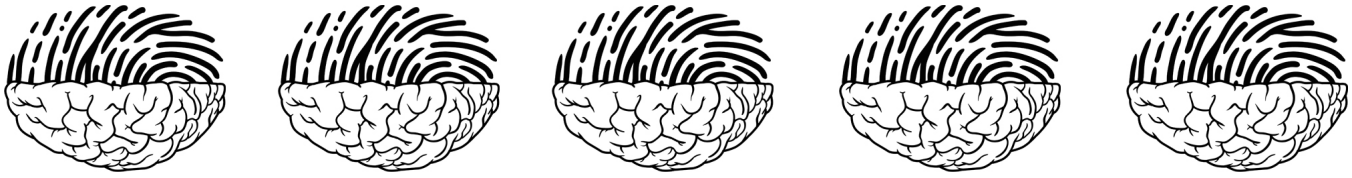
The Ontario Association of Interval and Transition Houses (OAITH) is a member-based coalition of first stage women shelters, second stage housing programs, and community-based women's organizations; Together, we work towards eliminating violence against all women in Ontario. Our initiatives include training and resource development, advocacy, public awareness, and government relations to improve social policies that impact women and their children.

In January 2018, OAITH received funding from the Ministry of Community and Social Services to lead a 4-year province-wide training and resource project focused on ending violence against older women (VAOW), by increasing the capacity of all professionals in Ontario who provide support, services, or care to older women experiencing violence.

Please visit the Aging Without Violence section of the OAITH website at www.oaith.ca to access a full list of current project advisory members, resources, tools, and training opportunities focused on older women experiencing violence.

Chapter 1
Trauma & The Architecture of the Brain

"Trauma is a concrete physical, cognitive, affective, and spiritual response by individuals and communities to events and situations that are objectively traumatizing." (1304)

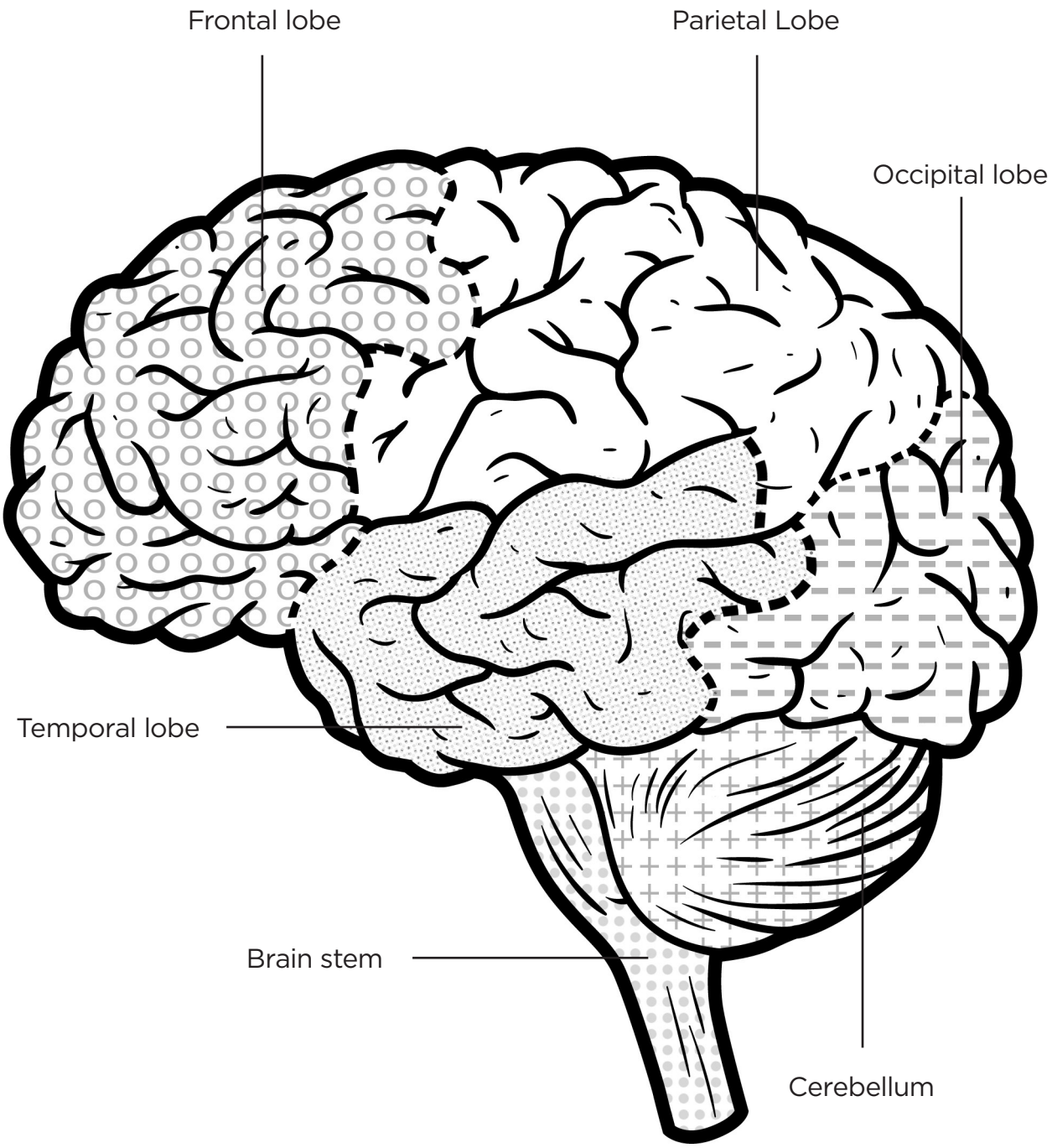


The human brain is amazingly complex. It adapts in response to experience and environment and changes with age. Understanding some of these changes will increase your capacity to work with women of all ages who have survived trauma, and in particular, older women who have diverse and unique barriers in accessing help.

As a starting point, this illustration shows the entire brain from a lateral view.

Suggested Colouring: Colour the frontal lobe PURPLE, the Parietal Lobe BLUE, the Occipital Lobe GREEN, the Cerebellum YELLOW, the Brain stem ORANGE, and the Temporal Lobe RED

Using the same colours for the same areas of the brain while you complete the entire Visual Training Tool will help to cement learning.


Frontal lobe
Parietal Lobe
Occipital lobe
Temporal lobe
Brain stem
Cerebellum

Trauma is an event (or series of events) which causes fear, horror, or terror, along with actual or perceived lack of control. Trauma also refers to the ways in which traumatic events can disrupt functioning. Women are about twice as likely as men to experience impacts of trauma which may be characterized as symptoms of Post-Traumatic Stress Disorder following any type of traumatic event (Voges and Romney, 2003).

Trauma includes: a one-time event (ie. a single sexual or physical assault); prolonged or repeat experiences (ie. interpersonal violence over decades by a partner); accumulative (ie. violence as a child, abuse, and racism) or historical events with prolonged impact (ie. colonization).

As well as individuals, entire communities as a collective whole can be traumatized. Individual trauma must be understood within the context of the broader systems of oppression and social disadvantage which impact marginalized women of all ages.

A trauma survivor may have lived through physical, sexual, emotional, and/or verbal abuse. She may have been traumatized by multiple perpetrators throughout her life. A woman may be in an immediately threatening situation that causes her to fear for her safety and/or life. We're going to view the brain through a trauma lens, so we'll focus on parts of the brain that are affected by fear – because when we talk about trauma, we're talking about fear.

Fear is a fundamental reaction that's evolved over the history of human life to protect us from threat ("Understanding the Stress Response," 2018). Fear commands our attention. When we're terrified, our thinking brain gives way to our emotional brain and the resulting defense cascade is automatic (Cuncic, 2018).

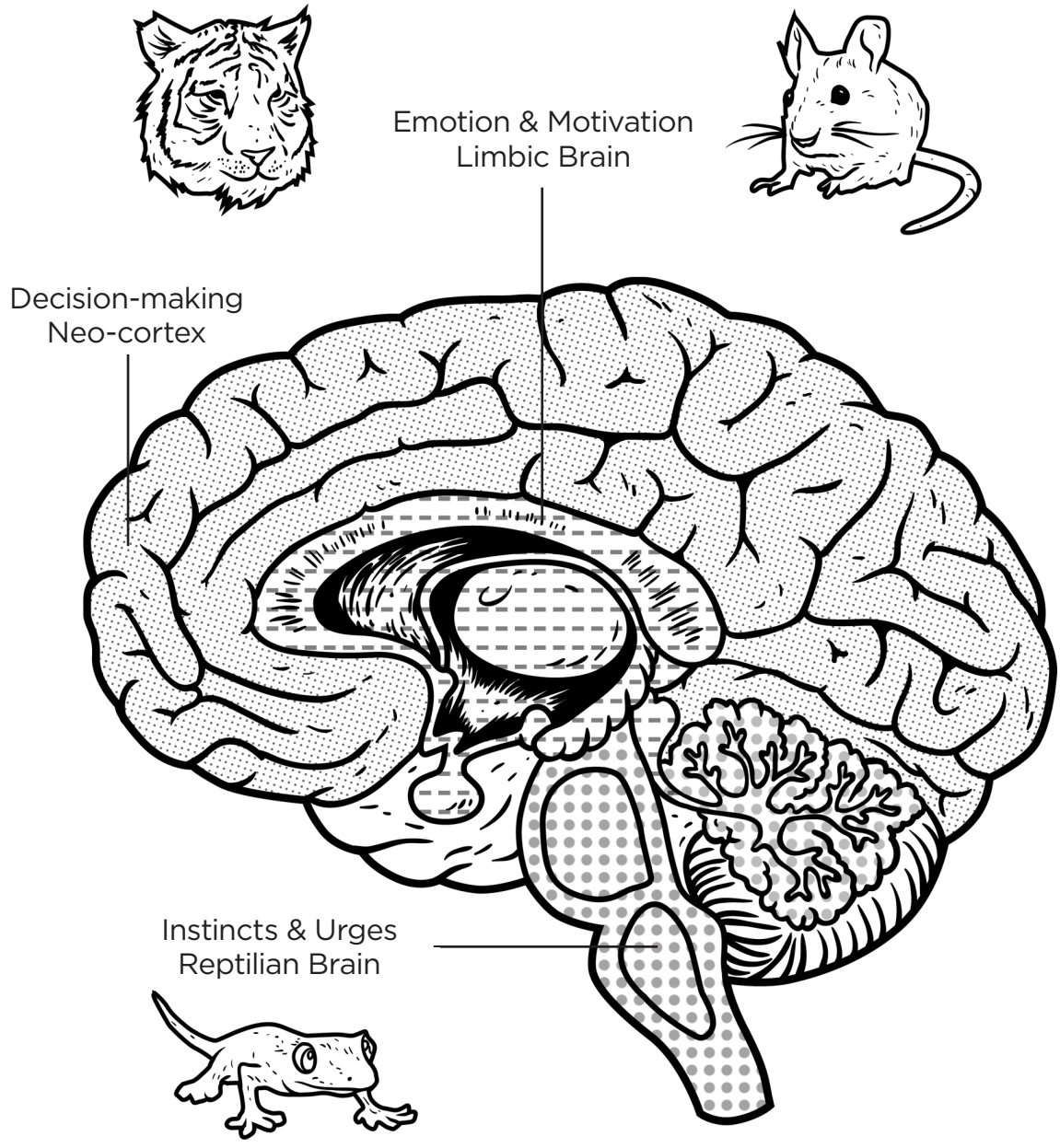
Decision, Emotion and Instincts

The brain is often divided into three parts, which are interconnected.

The neocortex is the newest part of the human brain, evolutionary speaking, and is responsible for language, learning, abstract thought, and memory.

All mammals have a limbic system, humans, tigers, and even mice.

The reptilian brain controls the body's vital functions including heart rate, breathing, body temperature and balance.



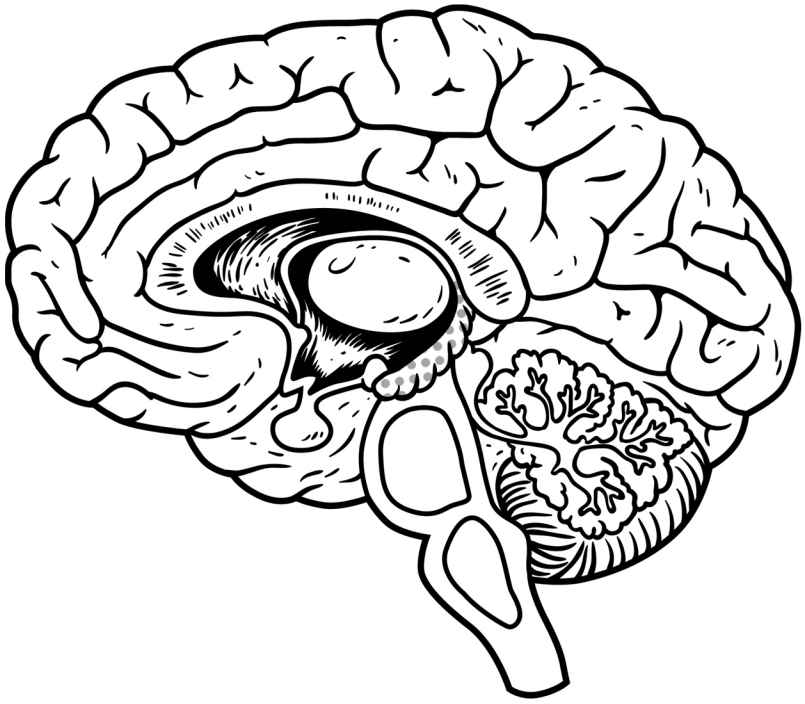
The Thinking Brain

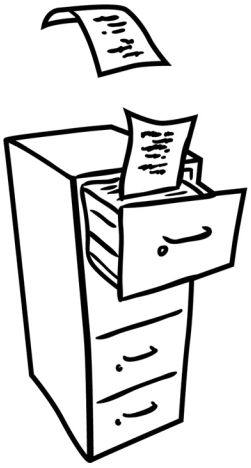
Your prefrontal cortex is the part of your brain that's responsible for rational thinking and planning. When you decide what to prepare for a meal, you're using your prefrontal cortex. It helps you to organize information and choose what to pay attention to; what you remember depends on what you pay attention to (Wilson, Lonsway & Archambault, 2018). When experiencing trauma, our brain chooses which details to pay attention to, and to what extent, based on our needs for survival.

The Emotional Brain

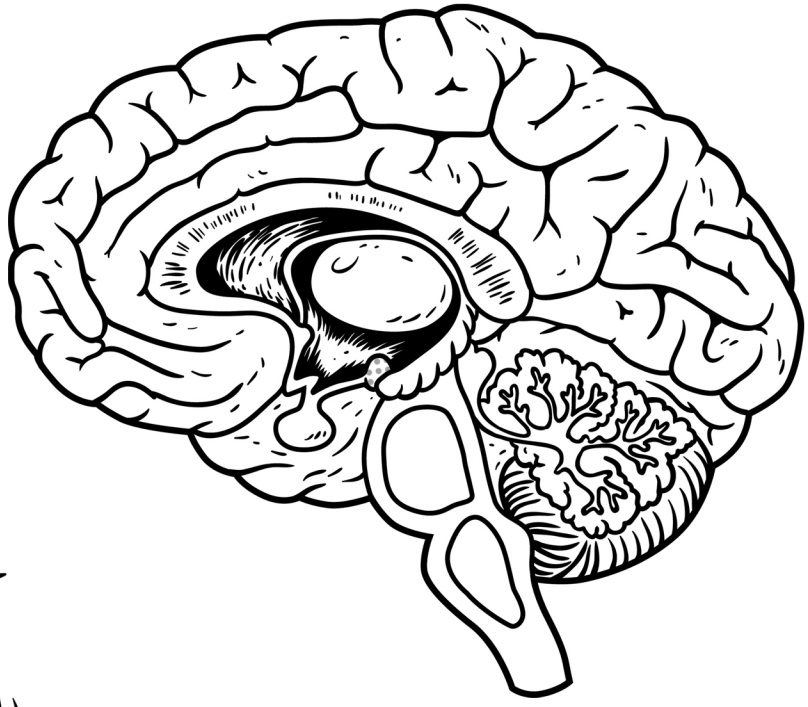
Now to the emotional brain – a group of structures that form the limbic system. The limbic system, also called the mammalian brain, originated before the prefrontal cortex. We share this part of the brain with all mammals – dogs, tigers and even mice. The limbic system allows us to feel love, hate, anger, joy, and fear. When a woman is threatened, her limbic system takes over; her brain chooses how she will respond before she can logically consider the outcomes of her actions (Bailey, 2018).

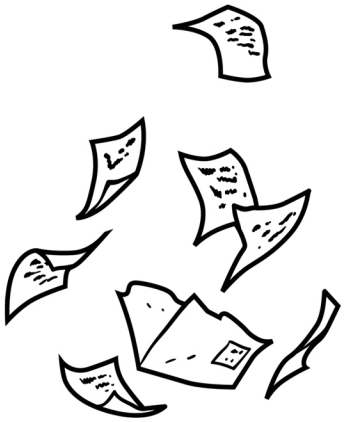
Parts of the limbic system that are essential to understanding a woman's trauma response are the amygdala, the hypothalamus, and the hippocampus.





No Danger





Brain Senses Danger

The amygdala recognizes emotional information, such as the expressions on people's faces, and plays a key part in conditioning – the largely unconscious learning process that has us approach things that reward us and avoid things that punish us. The amygdala is where the fear response starts, and like a smoke detector, alerts us to early signs of danger (Bailey, 2018).

Watch the supplemental AWV video online It's Just the Toaster which explains this metaphor in further detail.

Each individual's amygdala has a different level of sensitivity. If we think of the amygdala as a smoke detector, we might say a woman who has survived trauma has a keenly sensitive smoke detector mounted directly above a toaster, so the detector goes off frequently, even when there's no fire. Maybe in the course of your work, you've seen a trauma survivor become distressed without apparent reason. She has reason. Her detector senses smoke.

What other parts of the brain form the limbic system?

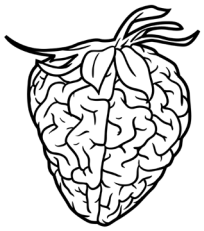
The **hypothalamus** is a command centre in the brain. It controls breathing, blood pressure and heartbeat. When a woman encounters a threat, her amygdala signals her hypothalamus, which tells her **adrenal glands** to send out **adrenaline** and **cortisol**, chemicals that prepare her body for action ("Understanding the Stress Response," 2018).

It's Just the Toaster
https://www.oaith.ca/oaith-work/aging-without-violence/vieiller-sans-violence-vsv.html

The **hippocampus** is critical for forming, organizing and storing memories. It also helps to link sensations with memories (Cherry, 2018). When a sound or smell or any bit of sensory information triggers a woman to recall or re-experience trauma, her hippocampus is making connections.

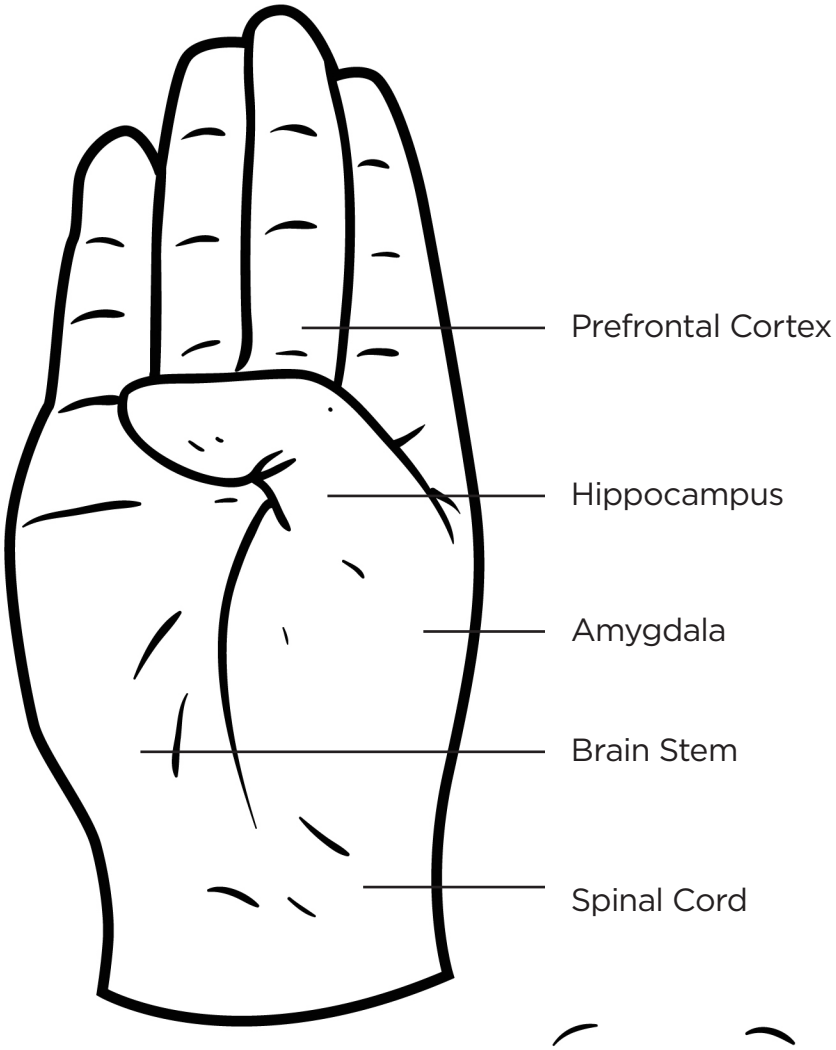
The **Flipping Your Lid** exercise shows how the prefrontal cortex and limbic system fit together. Try this now: Make a fist with your thumb inside your fingers; this is our model of the brain. Now hold your hand up so it faces you. Your thumb is the **limbic system**, your emotional brain (amygdala and hippocampus) and processes memory. Your fingers are **prefrontal cortex**, your thinking brain.

When memories of trauma are triggered or a trauma survivor feels threatened, she may flip her lid resulting in a poor connection between the prefrontal cortex (fingers) and the midbrain (thumb) and as a result, the logical, problem solving part of her brain is inaccessible (Bailey, 2018). Intense emotional reactions are likely when someone's lid is flipped.

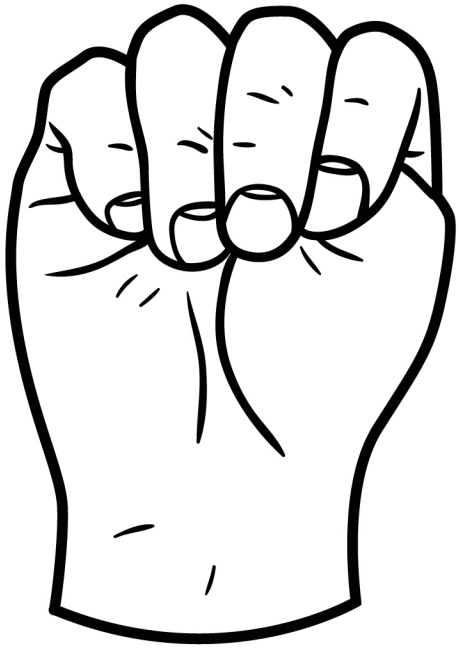


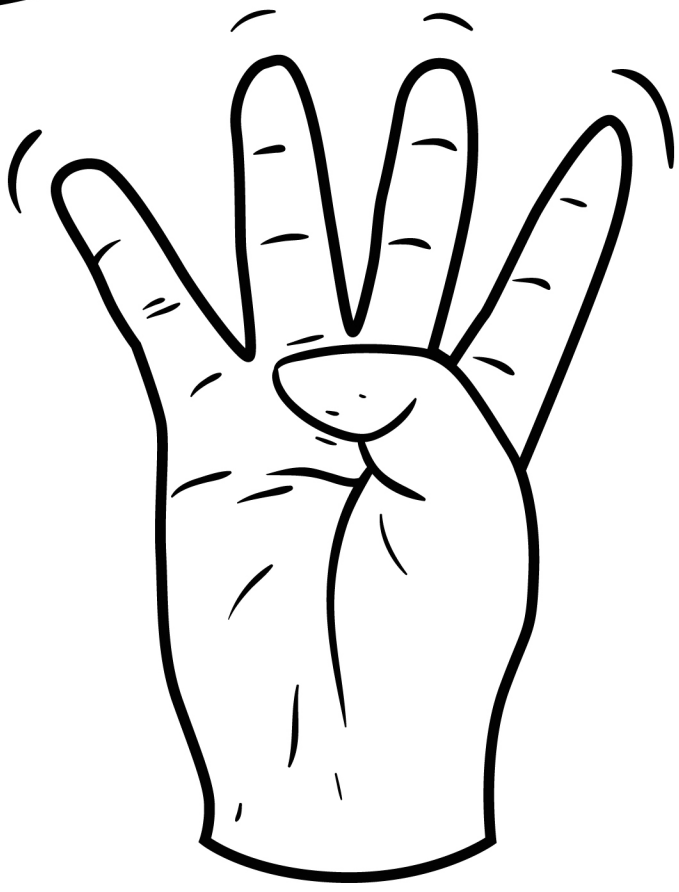
Food for Thought:

Have you ever "flipped your lid" at a time when it was inappropriate to express anger? How did you feel about your actions afterwards?



Calm - Thinking Brain Accessible



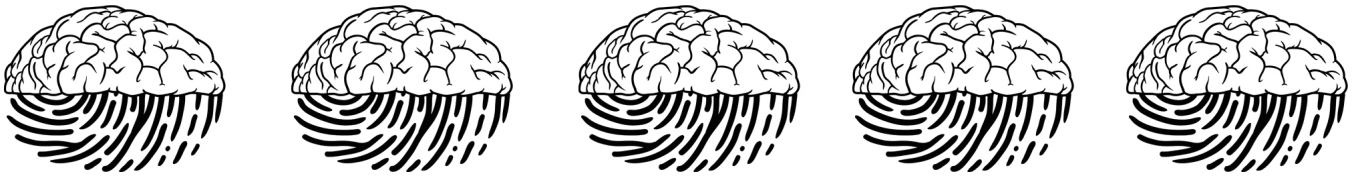


Fear - Emotional Brain Leads

Chapter 2
The Power Of The Brain

"The brain is a monstrous, beautiful mess. Its billions of nerve cells - called neurons - lie in a tangled web that displays cognitive powers far exceeding any of the silicon machines we have built to mimic it."

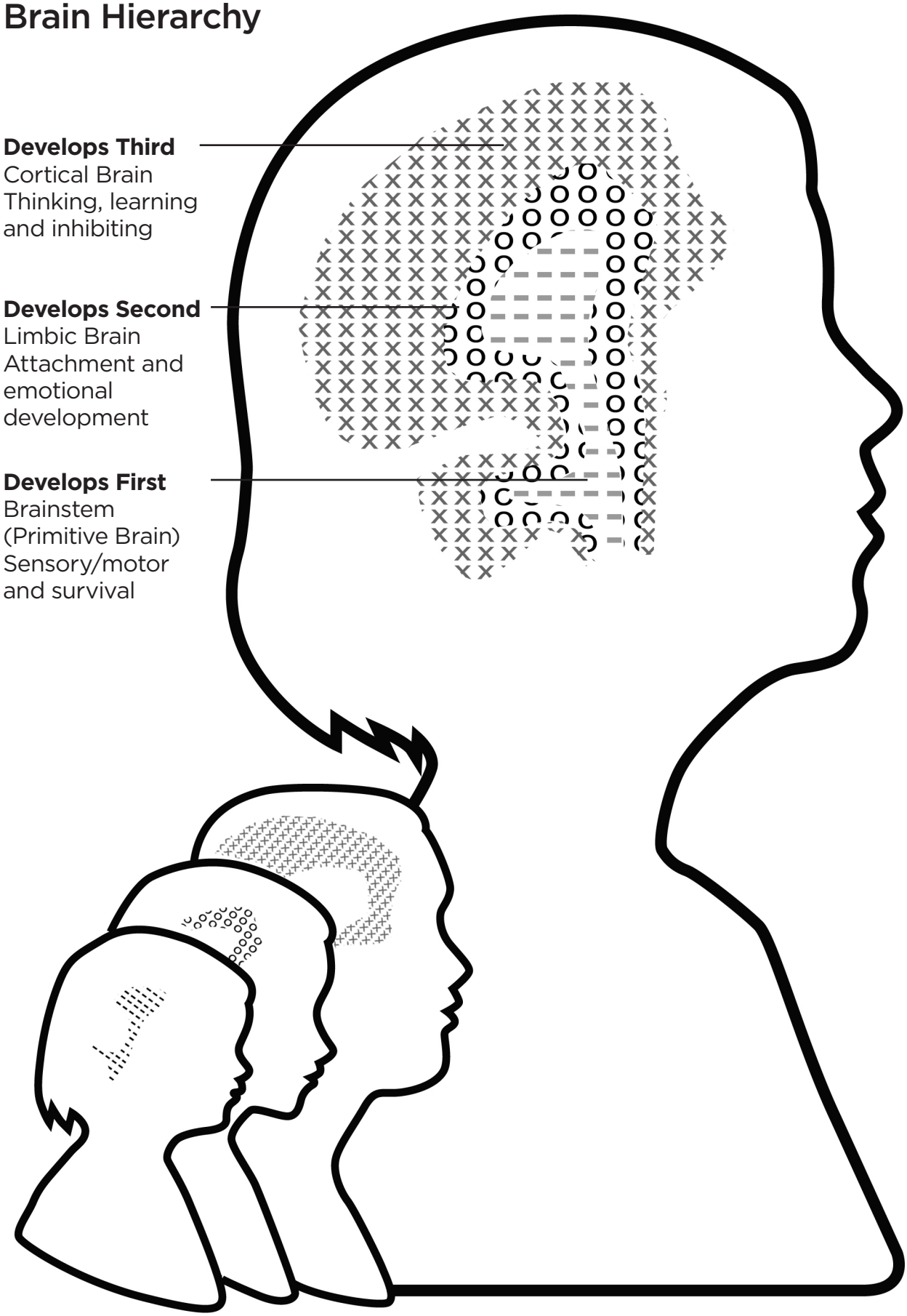
– William Allman, Apprentices of Wonder



Hierarchy of the brain:

A hierarchy is a set of things organized into layers. Your brain has a hierarchy in which the top layer usually manages the layers beneath. The top layer in the brain's hierarchy is the **cortex**, which includes the **prefrontal cortex**, which helps us to reason, use language, and imagine. Down a step in the hierarchy is the **limbic system** – the emotional brain which influences the way we relate to others. The bottom level of the hierarchy is the **brainstem**, which manages regulatory functions like breathing and heart rate ("The Structure and Function of the Human Brain," 2019).

Brain Hierarchy



This hierarchy is usually the order of things, but there are exceptions; When a woman is threatened, her thinking brain gives way to her emotional brain and she acts on instinct in order to survive.

How the brain communicates:

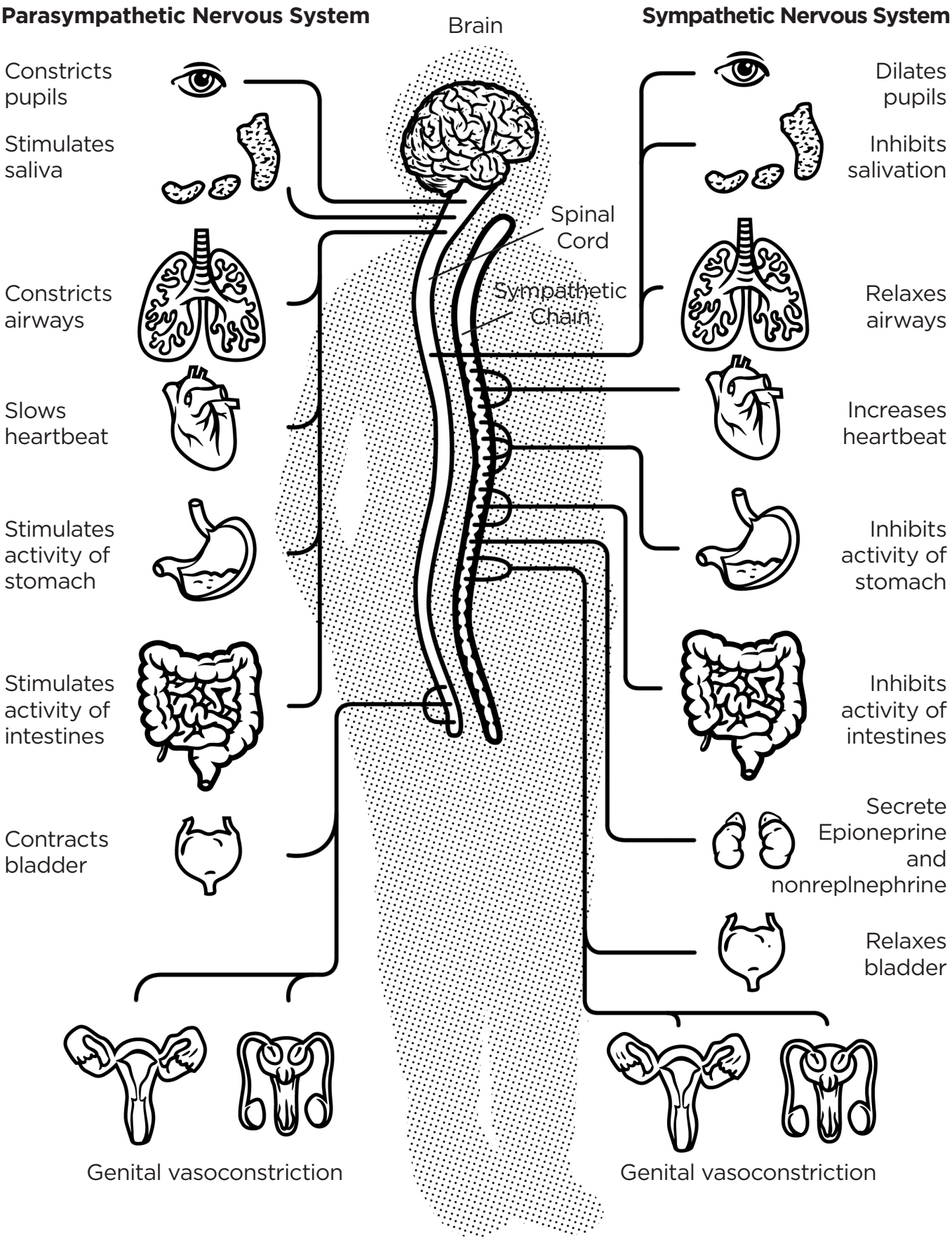
Brain cells that transmit information are called **neurons**. Most neurons are separated by tiny gaps called **synapses**. Neurons send chemicals called **neurotransmitters** across the gaps to message other neurons, sending signals of our sensations, thoughts and emotions (Brookshire, 2017).

Nerves are lines of communication that run through the body to the brain and are organized into various systems. We'll focus on the **Autonomic Nervous System (ANS).** The brain uses the ANS to communicate with other organs.

The ANS is made up of two parts: the **sympathetic (SNS)** and **parasympathetic nervous systems (PNS)**. The sympathetic nervous system "revs" the body for vigorous activity. The **parasympathetic nervous system** facilitates reduction in heart rate and other non-emergency responses (Kalat, 2013).

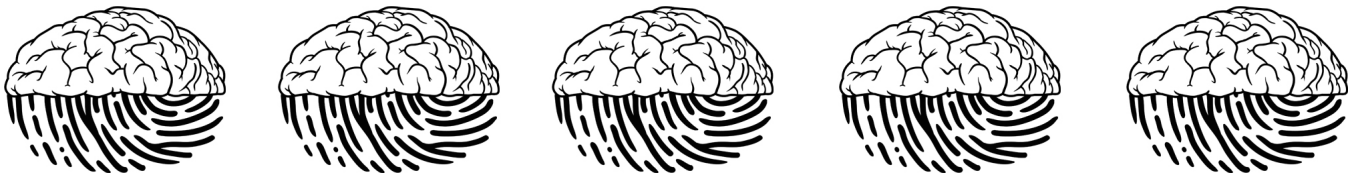
Trauma has significant impacts on the ANS, as threats activate both the sympathetic and parasympathetic nervous systems. In particular, childhood trauma can affect a woman's lifelong ability to regulate the SNS and PNS systems when experiencing even minor stressors.

Nervous System



Chapter 3
The Trauma Response

"When threatened or injured, all animals draw from a "library" of possible responses. We orient, dodge, duck, stiffen, brace, retract, fight, flee, freeze, collapse, etc. All of these coordinated responses are somatically based- they are things that the body does to protect and defend itself."
– Peter Levine



When a woman senses danger or is attacked, her body sends automatic signals to her brain to alert her nervous system that there is a threat to her safety and a cascade of neurobiological defense responses is set off, which is often over simplified as "fight or flight". A woman does not choose which response is initiated during an attack but may feel guilt, shame, confusion, and anger for not responding a certain way during a violent attack. Often survivors are questioned about their actions and physical responses during an attack. Even decades after a traumatic incident (such as childhood sexual abuse) a smell, sight, sound, touch, or taste may trigger memory fragments and initiate a defense cascade response for an older woman. This trauma response effectively impairs the rational, logical, thinking part of the brain, which is further confused by the attachment circuitry activated at the same time as fear circuitry, when a woman experiences violence from someone she knows and trusts. Attachment circuitry also suppresses a woman's defense circuitry.

The "F's" of Survival

Freeze: The stop, look, listen stage. The woman's **parasympathetic nervous system** slows her heart; meanwhile, her **sympathetic nervous system** gets her muscles ready for action.

Flight and Fight: The woman becomes **hyperaroused**. Her **sympathetic nervous system** prepares her to flee or, if flight is impossible, to fight. Her heart rate and breathing accelerate. Blood flows to her arm and leg muscles.

Fright: The woman panics, feels nauseous, dizzy. Her **sympathetic** and **parasympathetic nervous systems** are both highly active, which might make her switch actions abruptly.

Flag: The stage of despair. The woman's **parasympathetic nervous system** takes over. Her heart rate and blood pressure drop. Her **embodiment circuitry** – the system in her brain that lets her feel her body – is compromised. She might have trouble moving. She could feel numb, separate from herself. We call this state of disconnection **hypoarousal**.

Faint: If the threat doesn't resolve, a **parasympathetic surge** could slow the woman's heart rate, decrease oxygen flow to her brain, and disrupt signals from her brainstem that maintain muscle tone. This disruption could render the woman immobile and cause her to collapse. **Collapsed immobility** is a term used to describe this response.

(Follette, Briere, Rozelle, Hopper, Rome, 2014; Kozlowska, Walker, McLean, Carrive, 2015; Schwartz, 2016).

Disassociation, Tonic Immobility and Collapsed Immobility

Disassociation is the brain's way of disconnecting the body from a traumatic experience, or the impacts of trauma.

It is common in trauma survivors and may be misidentified as intoxication, unwillingness to cooperate, and deception. Women who have experienced extreme fear, physical contact with the perpetrator, physical restraint and/or a perception of inescapability may also experience **Tonic Immobility** during an assault.

Tonic immobility (Freeze-Fright) is where a person (also seen in animals such as deer, sharks, mice, and rabbits) is extremely afraid and becomes immobile, with rigid/stiff limbs, while frozen, maintain their position. **Tonic immobility** may include fixed or unfocused staring, sensations of coldness, faintness and numbness or insensitivity to pain. They may have intermittent periods where their eyes are closed. A woman is frozen with fear, unable to move or talk, but may be alert or aware, or may be experiencing **dissociation**. This may last seconds or hours and terminate suddenly. This was previously referred to in sexual assault cases as "rape-induced paralysis."

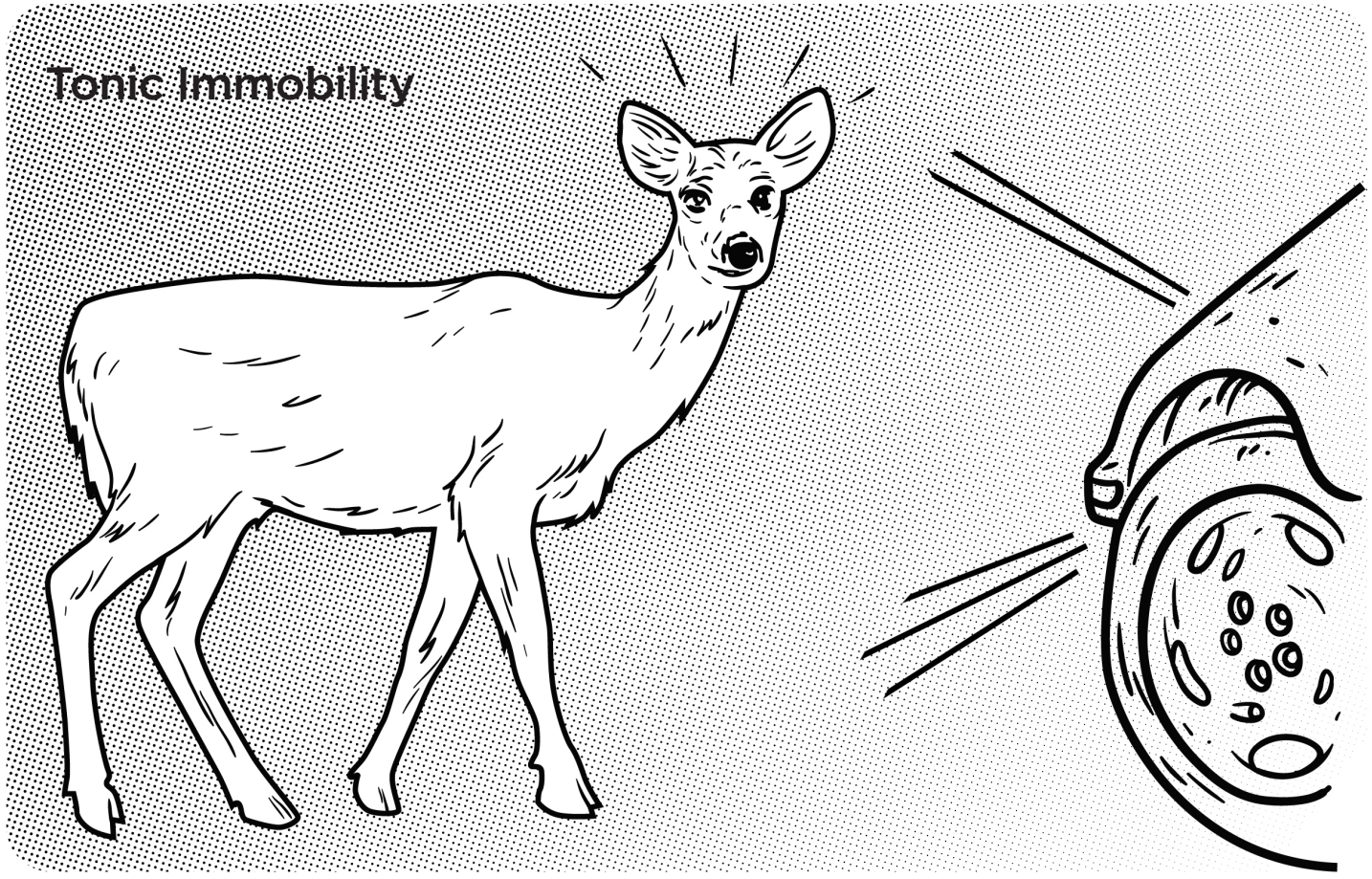
Collapsed immobility is sometimes called "playing dead" although, this description is inaccurate as the brain has chosen this defense. It is characterized by decreased heart rate, blood pressure, and reduced oxygen to brain, rendering the woman unable to speak or move, in addition to loss of muscle tone. This may be described by a survivor as pretending to be asleep during the attack, fainting or blacking out as she tries to make sense of a confusing and terrifying assault.

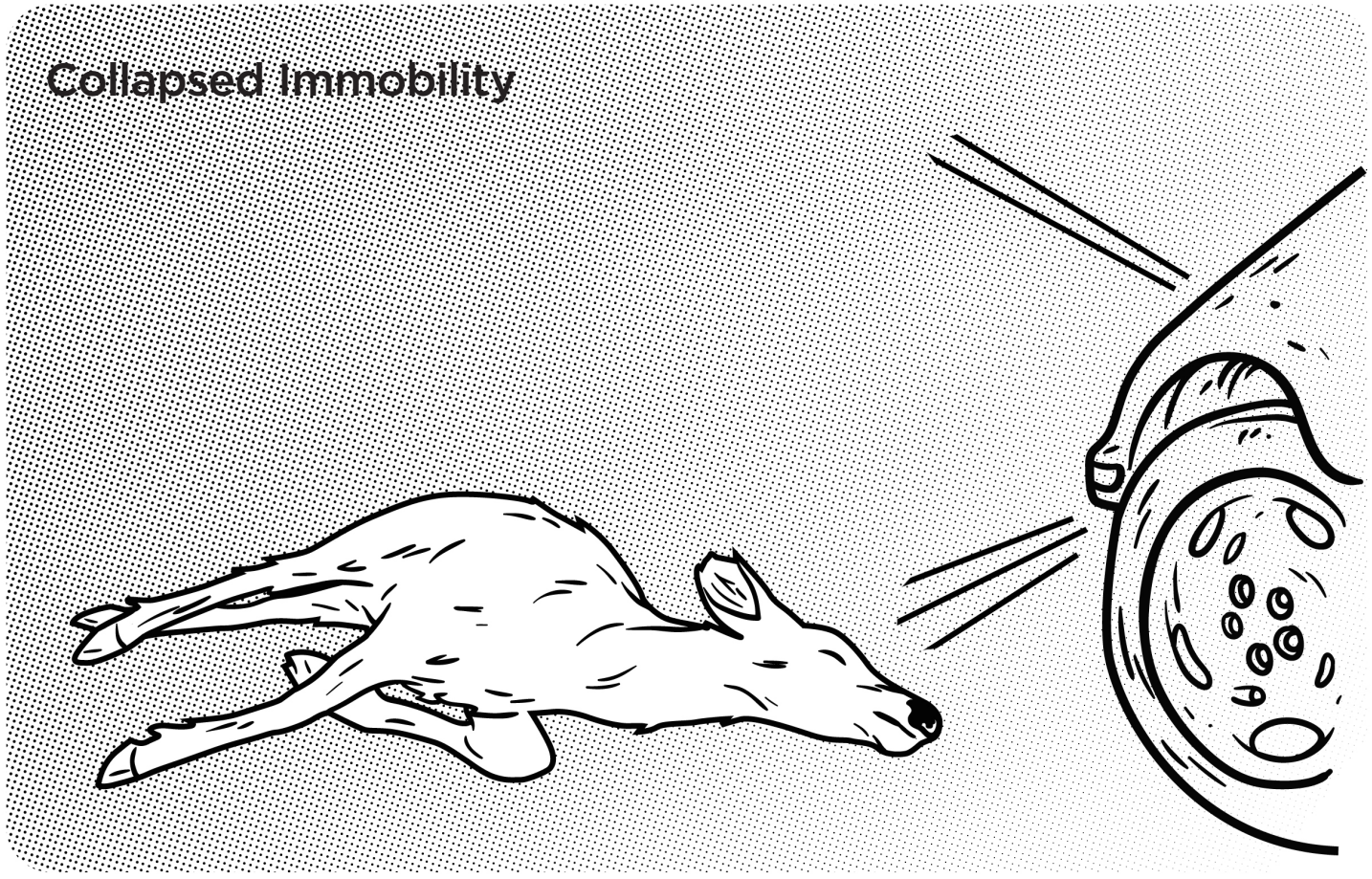
Hormones Released During Trauma

Hormonal responses to trauma may appear immediately following, several hours afterwards, or several days after a trauma (Smith, 2017).

FREEZE: Opiates and oxytocin to counteract physical pain and increase positive feelings

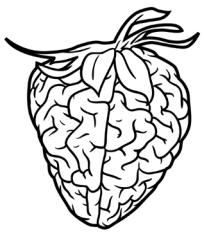
FLIGHT/FIGHT: Cortisol and catecholamines to increase energy and adrenaline


Tonic Immobility


Collapsed Immobility

Many women experience tonic immobility during a sexual or physical assault; paralysis that lasts for seconds, minutes, even hours. The woman can't speak or move, but remains alert. After the assault, she might blame herself for not having resisted.

A woman who has survived an assault may tell you she feels "spaced out," "numb," or "disconnected." Letting her know these are natural responses that many survivors of trauma experience can help her to feel supported, less alone, and hopeful that her feelings of disconnect and numbness might change.



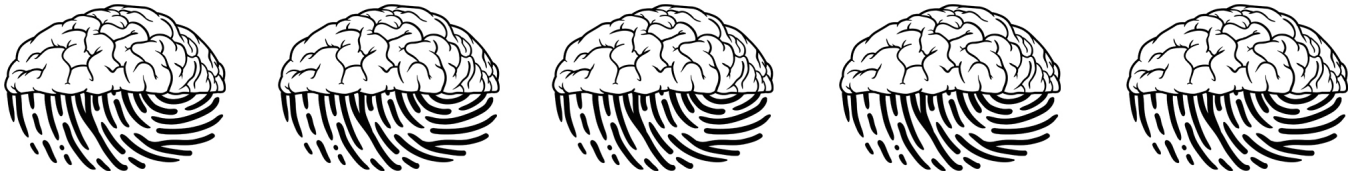
Food for Thought:

- Has a woman ever told you that during an attack, she was unable to move? How might trying to recall the attack make her feel?
- What factors might be important to consider in your tone of voice, behaviour, actions, and physical meeting space with a woman who has experienced complex trauma?

Chapter 4
The Legacy Of Trauma

"Intergenerational trauma is directly linked to the banning of cultural practices, policies and institutions of assimilation, and loss of culture. It is a reaction to multigenerational, collective, historical wounding of the mind, emotions and spirit."

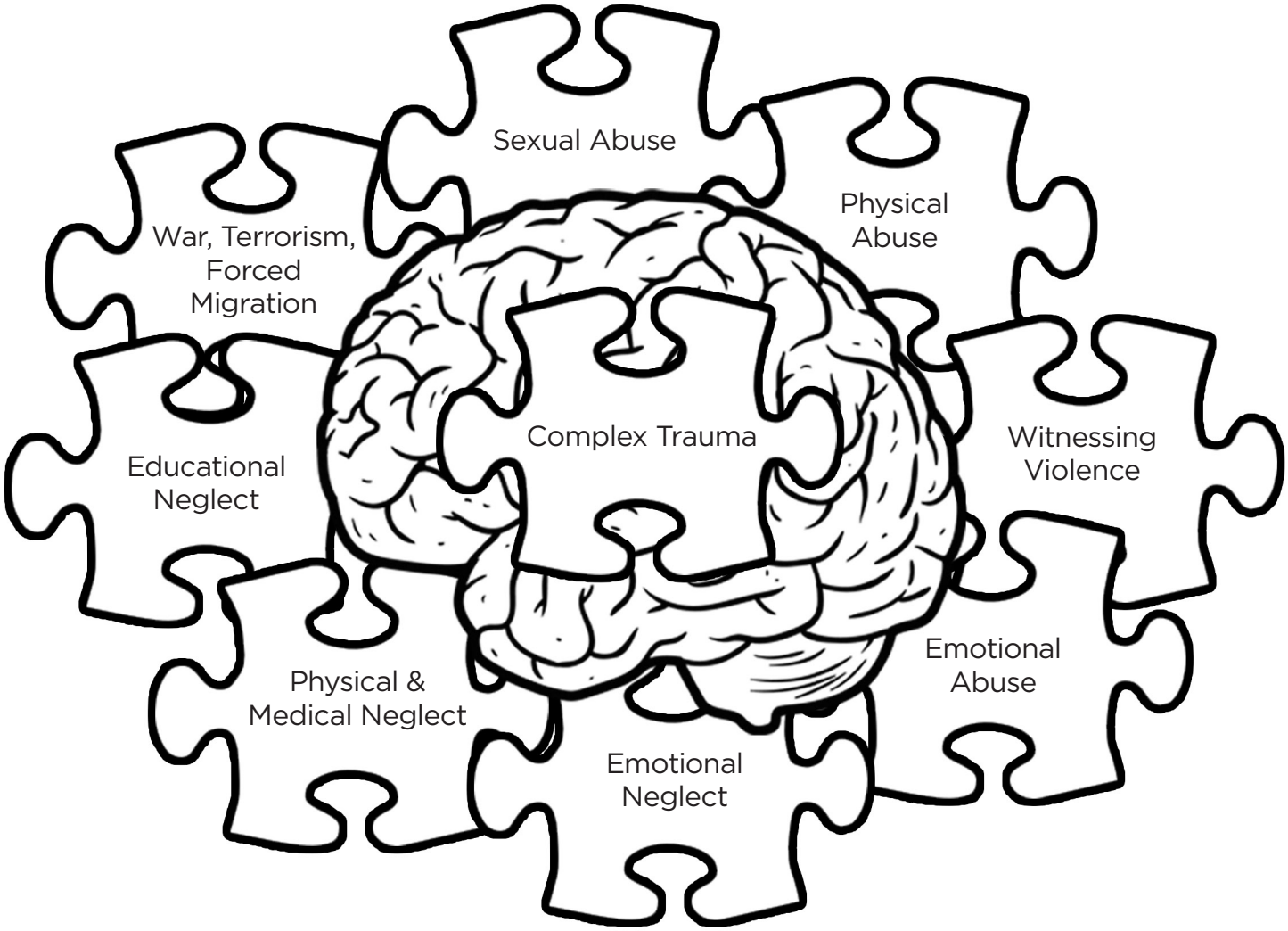
(The Soul Wounds of the Anishinabek People, 2013, page 8)



Trauma perpetuates itself. It's handed down from generation to generation in families (**Intergenerational Trauma**) and in cultures and populations where people have been oppressed and abused (**Historical Trauma**) (Intervention to Address Intergenerational Trauma, 2012). Most interpersonal trauma suffered by children is inflicted by people who were subjected to trauma early in their lives. This tendency to repeat is an integral aspect of what's called "the cycle of violence" (Van Der Kolk, 1989).

Many older women who have suffered complex trauma have experienced violence from a number of perpetrators. Some of these women might never have disclosed their trauma – even in cases where the abuse began when the women were young.

The term **Complex Trauma** describes the experience of multiple traumatic events that start early in a woman's life. If a child suffers trauma, it's likely the trauma is part of a series of traumatic events. Complex trauma can include sexual abuse, physical abuse, war, community violence, and neglect. It can also include witnessing violence – if a child sees one parent abusing the other, or sees a sibling or another young person being abused (Trauma-Informed, 2013).

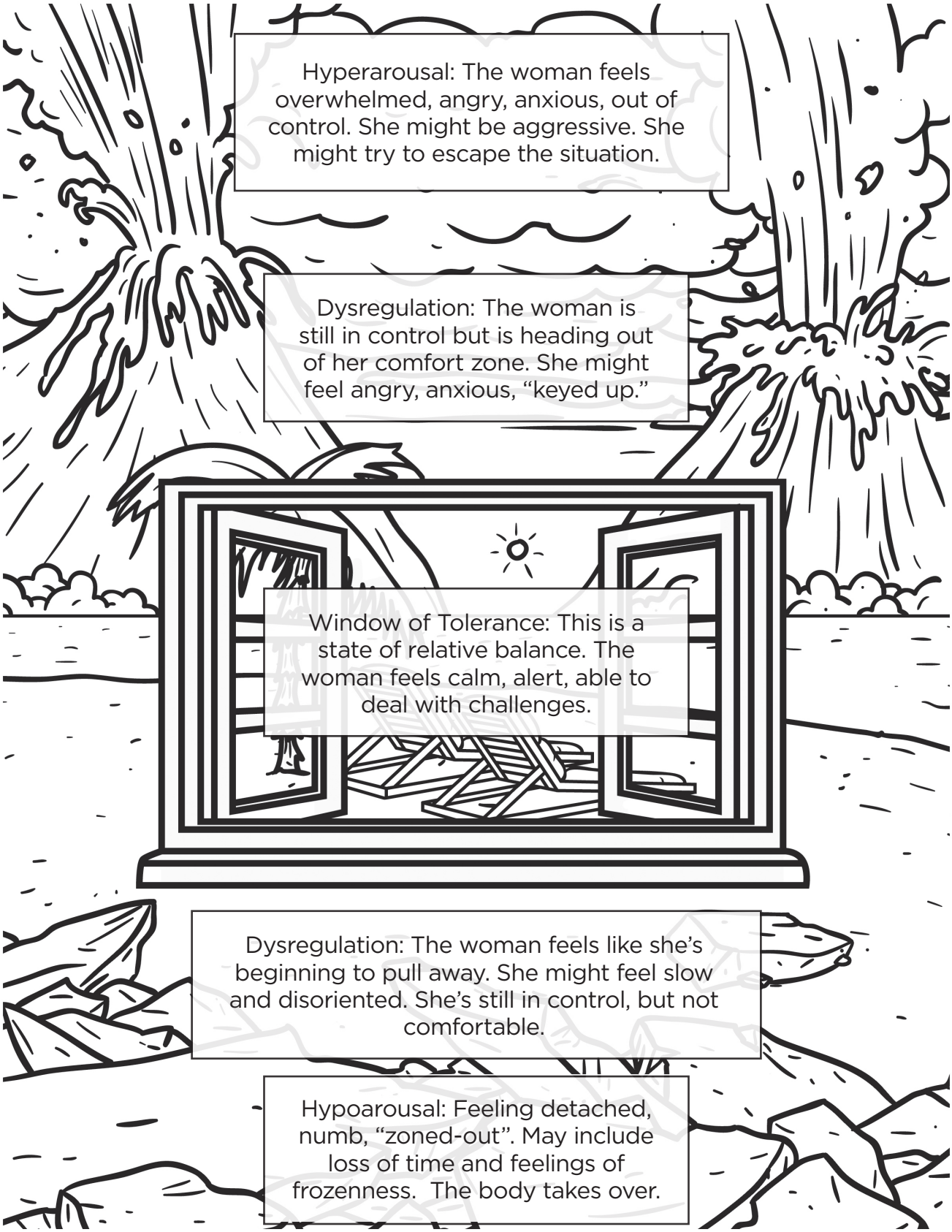


A woman who has experienced complex trauma may find herself seized by powerful emotions she can't control. She may burst out with these emotions in ways that frighten her and the people around her. Her outbursts may be prompted by seemingly minor stimuli; We call this mode of reaction emotional dysregulation, and it is characteristic of complex trauma (Franco, 2018). In your work, you may see a woman become angry or afraid for no obvious reason. Possibly, in these moments, something in the environment has triggered her to enter a highly emotional state.

Understanding the effects of trauma as natural, protective responses, which are based in resiliency and survival, helps to understand the critique of psychiatric approaches to trauma; for example, diagnosing trauma responses using the Diagnostic and Statistical Manual of Mental Disorders (DSM). Ultimately, it may be more helpful to your client to understand her responses to trauma as coping skills rather than symptoms of a mental health disorder. Diagnoses, including PTSD, have also been criticized as divorced of an intersectional lens and of the reality of the social structures within which we live and experience violence (Burstow, 2003).

Emotional Dysregulation & the "Window of Tolerance"

Trauma affects a woman's "window of tolerance"- however trauma-informed support and services can enlarge this window.



Intergenerational and Historical Trauma

When unresolved, **Historical Trauma** is passed from one generation to the next, we call it **Intergenerational Trauma** or **Multi-Generational Trauma**. When a group of people who share an affiliation (ethnicity, race, religion), have been oppressed and abused over successive generations, we refer to the abuse as **Historical Trauma**. We don't have to look far to see the devastating effects of **Historical Trauma**. In Canada, Indigenous peoples have suffered discrimination, harm, loss of life and systemic deculturalization – abuses condoned by society and encouraged by government policy (Allan & Smylie, 2015).

> "Indigenous social and cultural devastation in the present is the result of unremitting personal and collective trauma due to demographic collapse, resulting from early influenza and smallpox epidemics and other infectious diseases, conquest, warfare, slavery, colonization, proselytization, famine and starvation, the 1892 to the late 1960s residential school period and forced assimilation... Since contact, First Nation people have experienced several waves of traumatic experience on social and individual levels that have continued to place enormous strain on the fabric of Aboriginal societies across the continent." (Aboriginal Healing Foundation, 2004).

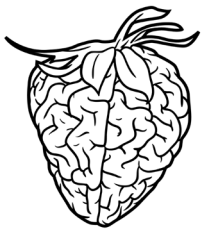
Over the past four decades, it is estimated over 20,000 Indigenous children have been removed from their family homes by child intervention services and placed into the care of mostly non-Indigenous families and separated from their community, culture and language (Paradis, 2018). The "Sixties Scoop" refers to a period in Canadian history beginning in the 1960s, however this is more accurately described as the "Millennium Scoop" and an ongoing crisis; There are more than three times the number of Indigenous children placed in the care of the province today than at the height of the operation of the residential school system (Blackstock, 2010).

In Ontario, Indigenous children represent only 4.1% of the population under 15, but approximately 50% of children within foster care; This over representation increases as the child welfare service decisions become more intrusive/extreme. ("Interrupted childhoods" OHRC, 2018). Although Métis and Inuit children are also overrepresented within child welfare systems, First Nations children are by large the most overrepresented, with First Nations children under 19 representing 3% of the child population in Ontario and 21% of all provincial wards (Kozlowski, et al. 2012).

Systems, service providers, and policies often fail to contextualize welfare concerns, in particular, neglect, related to Indigenous children within the history of colonization in Canada; ; in many cases, concerns including educational and medical neglect due to lack of financial resources, are ultimately rooted in structural factors largely beyond a caregiver's control such as social poverty, substance misuse and inadequate housing (Blackstock, 2010).

An older Indigenous woman you work with may have been abused in the residential school system, taken away from her family by child welfare services, or had her competency as a caregiver questioned by service providers and systems. She may have been traumatized so deeply and at such a young age that she has no language

to describe the trauma; she may have spoken of her trauma and not been believed. In your interactions with a survivor of historical trauma, or any type of trauma, know that she may have reached out before and been denied the help she sought, and that it may have been services and systems which perpetuated the most impactful trauma in her life. Also remember the healing power of respect, empathy and compassion.

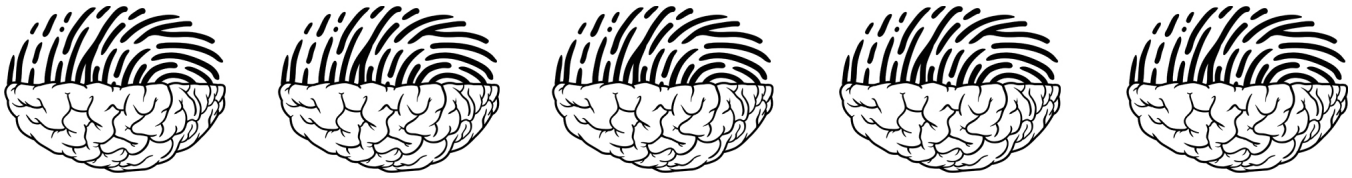


Food for Thought:

- What systems and services might a survivor of a residential school be hesitant to engage with? What strategies might be helpful in building trust?
- What supports are in/near/accessible to your community specific to Indigenous women?

Chapter 5
Effects Of Trauma

"From the outset, trauma challenges the just-world or core life assumptions that help individuals navigate daily life... it would be difficult to leave the house in the morning if you believed that the world was not safe, that all people are dangerous, or that life holds no promise."
(Centre for Substance Abuse Treatment, 2014).

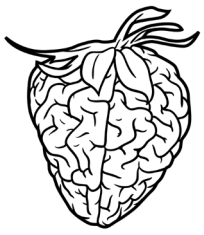


No two people respond to trauma in the same way; The strength of a woman's support system, her unique set of coping skills, and the nature of the trauma she endures, are all factors which shape the impact of trauma on her brain, body, and overall life.

If the effects of trauma interfere with a woman's functioning for longer than a month, she might be diagnosed with PTSD or Complex PTSD by a mental health professional ("DSM-V Criteria for PTSD," 2018).

Symptoms of PTSD as outlined in the DSM include: re-experiencing the traumatic event over and over; having disturbing memories of the event; avoiding reminders of the trauma; inability to feel pleasure; difficulty focusing; problems with memory and sleep; hypervigilance ("DSM-V Criteria for PTSD," 2019).

Trauma that an older woman has survived can influence her experience of aging – even if the trauma happened when the woman was a child and she can't recall it fully or at all. Trauma puts an older woman at increased risk of developing heart, liver, autoimmune and neurodegenerative disease, as well as mental health conditions like depression, anxiety, and psychosis (Substance Abuse and Mental Health Services Administration, 2014). Trauma survivors are more likely to experience distressing symptoms of menopause that include sleep disturbances, night sweats, vaginal dryness and pain during intercourse (Nogrady, 2018). Too often, the trauma a woman has experienced is unrecognized as a pivotal factor on her overall wellness and mental health.



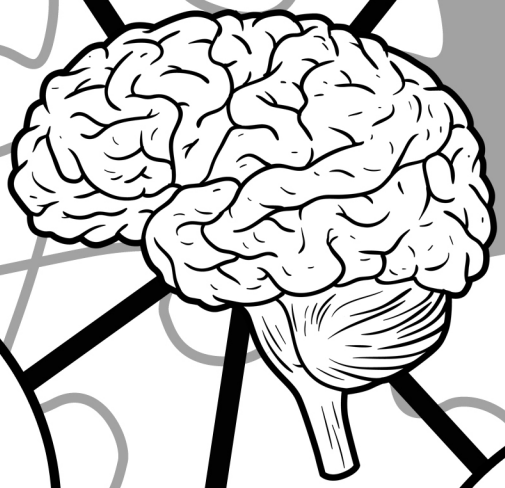
Food for Thought:

- What makes up a "support system"? What relationships and circumstances might be involved?
- Was there ever a time you had to endure something difficult alone?
- What – and who – makes you feel supported?

Effects of Trauma on the Brain

Physical
- Chronic pain/numbness
- Headaches
- Respiratory problems
- Sleep problems
- Digestive issues

Emotional/Cognitive
- Trouble concentrating
- Irritability
- Fear, anxiety, depression
- Difficulty managing anger
- Dissociation
- Memory and time loss
- Emotional numbness/ flatness



Behavioural
- Overspending
- Substance use
- Isolation from family, friends
- Involvement in the justice system

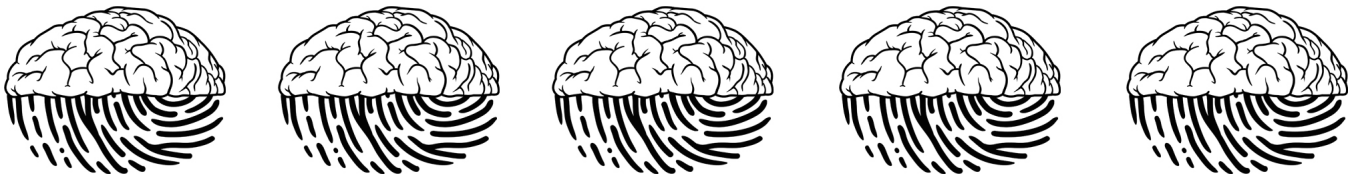
Spiritual
- Loss of connection to faith/higher power/ spirituality, community, nature, self, family community
- Feelings of guilt, shame, and self hate

Interpersonal
- Difficulty maintaining relationships
- Trouble setting boundaries
- Lack of trust

(Haskell et. al 2003).

Chapter 6
Trauma & Concurrent Health Issues

"The greater the trauma, the greater the risk for alcohol abuse... drug use, depression, suicide attempts, and other negative outcomes. Clearly, we cannot begin to address the totality of an individual's healthcare, or focus on promoting health and preventing disease, unless we address trauma." (Rosenberg, 2011, p. 428).



Trauma and Age-Related Health Conditions

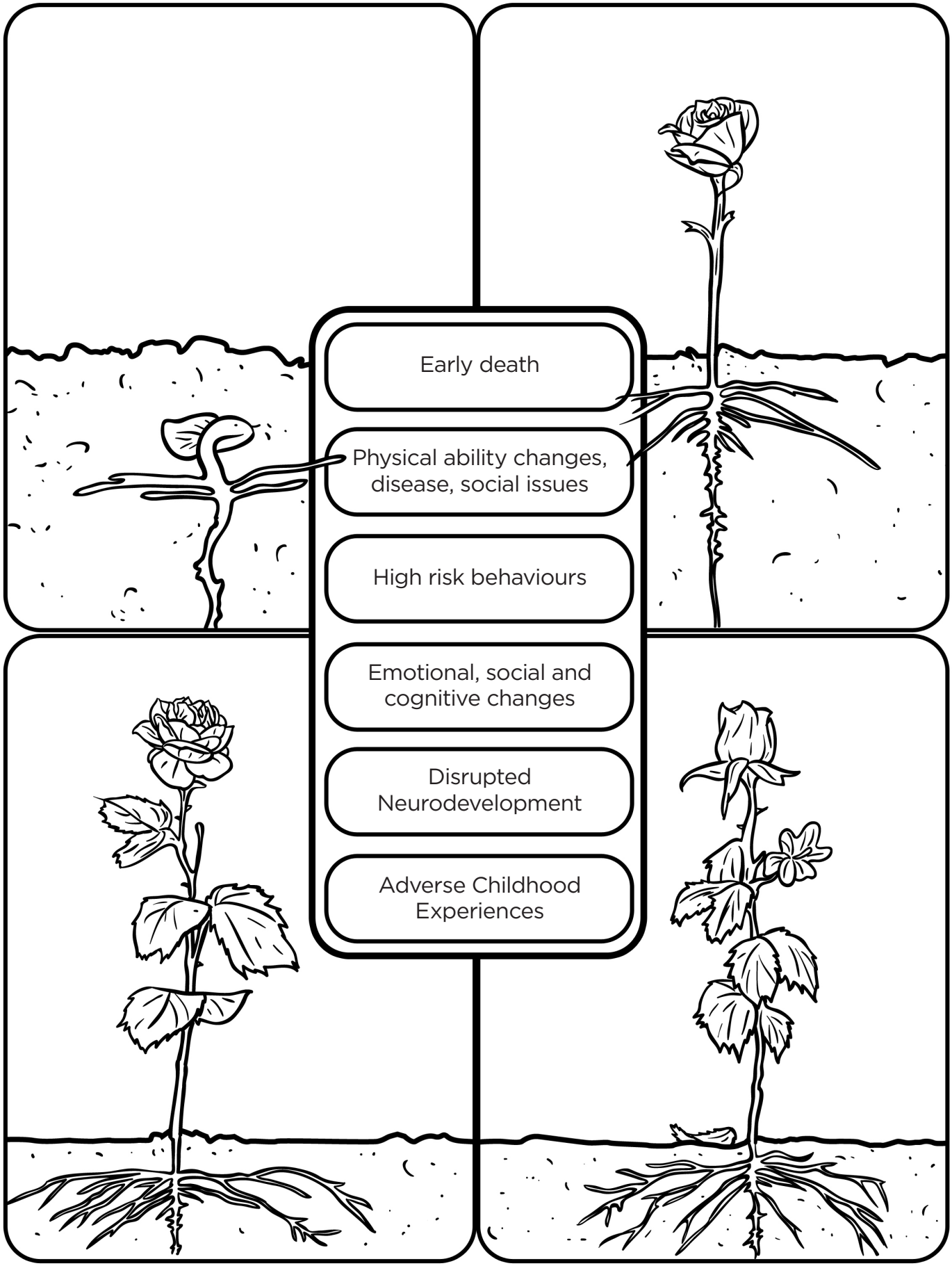
As we age, our bodily functions, thoughts, behaviours and emotions will change; Trauma speeds up the aging process. Scientists can actually "see" this acceleration on a cellular level. Studies suggest that trauma survivors have an increased risk of developing cardiovascular disease and Type 2 diabetes (Wolf, 2016). Women who have experienced trauma tend to have shorter lifespans than their counterparts who have not experienced trauma (Lohr, et al., 2015). Trauma a woman suffers in childhood can continue to impact her health and well-being as she ages.

Trauma and Neurodegenerative Disease

The term neurodegenerative disease refers to a range of diseases that result in the destruction of the brain and nervous system, including: Alzheimer's disease, Huntington disease, and Parkinson's disease. A woman's risk of being affected by neurodegenerative disease increases dramatically as she grows older (Neurodegenerative Diseases, 2019). Many neurodegenerative diseases are associated with dementia (ONDRI Diseases, 2019).

When memory and cognition problems are severe enough to interfere with a woman's daily life, the impairment is classifiable as dementia ("What is Dementia," 2019). A woman with dementia might be disoriented. She might struggle for words, forget names. She might become aggressive, experience decreased interest in social activities, or be suspicious of others ("10 Warning Signs," 2019).

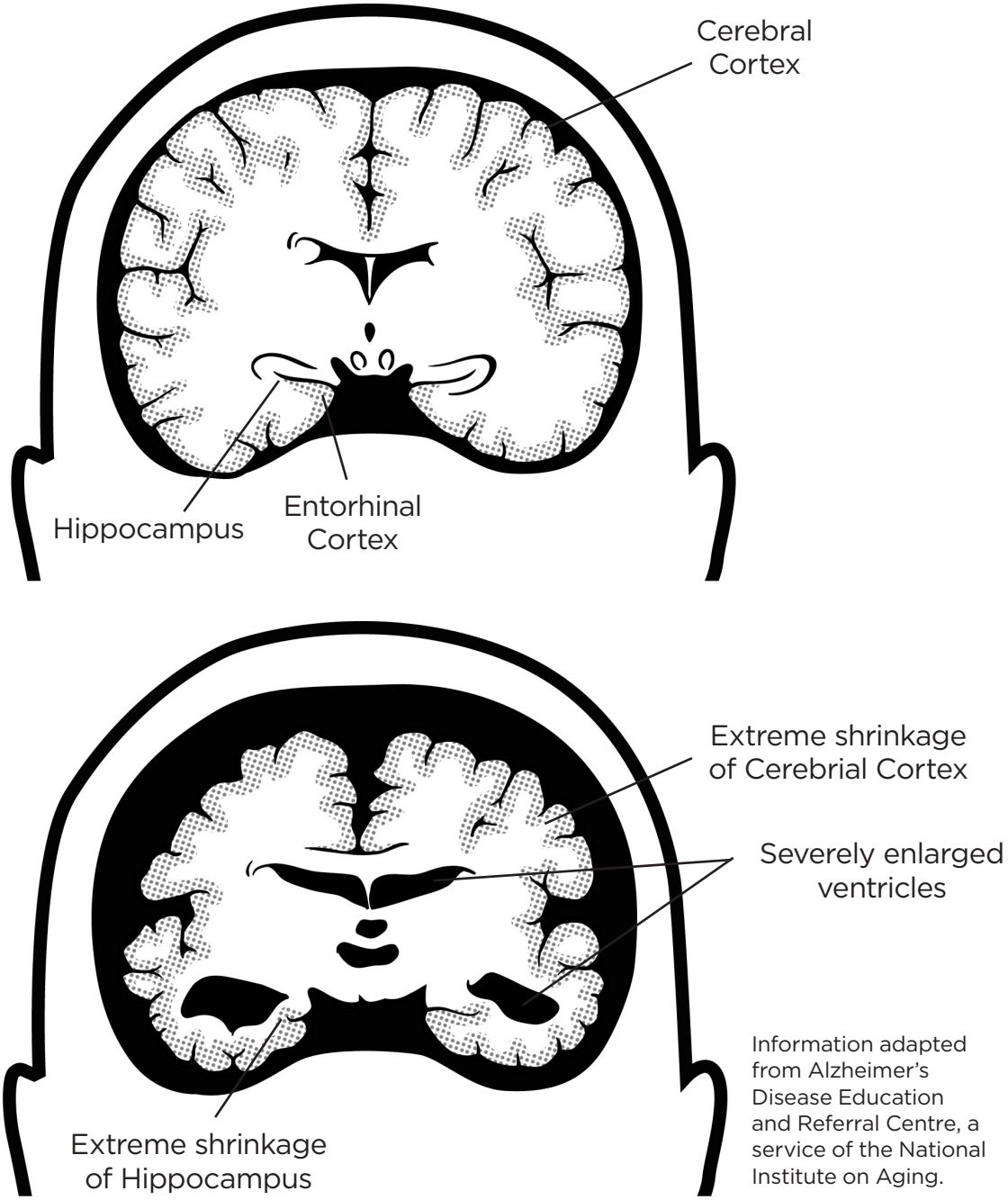
Effects of Trauma Across the Lifespan



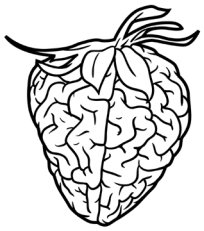
It's possible for an older woman's dementia to be compounded by trauma that she has survived or is experiencing. Perhaps she's being abused by a partner or family member. It's especially difficult for women with dementia to access support services as they're less able to communicate and navigate systems.

Dementia Effects and the Brain

Compare the two brain images below. The first image depicts a healthy brain, while the second shows the brain of a person with dementia. Note how much smaller the brain on the right is. Note too how the **ventricles** – cavities in the brain – are enlarged in the brain on the right. Reduced brain volume is characteristic of many types of dementia.



Information adapted from Alzheimer's Disease Education and Referral Centre, a service of the National Institute on Aging.



Food for Thought:

- How would cognitive changes associated with dementia affect a trauma survivor's ability to navigate services, retain information, and attend appointments? What actions could be taken to mitigate any barriers?

Traumatic Brain Injury and Violence Against Women

A **Traumatic Brain Injury (TBI)** is any injury to the brain that's caused by an outside physical force and includes injuries which are penetrating, such as a bullet piercing the skull, or a closed head injury such as force from a blunt object or jolt to the head from a surface such as the wall.

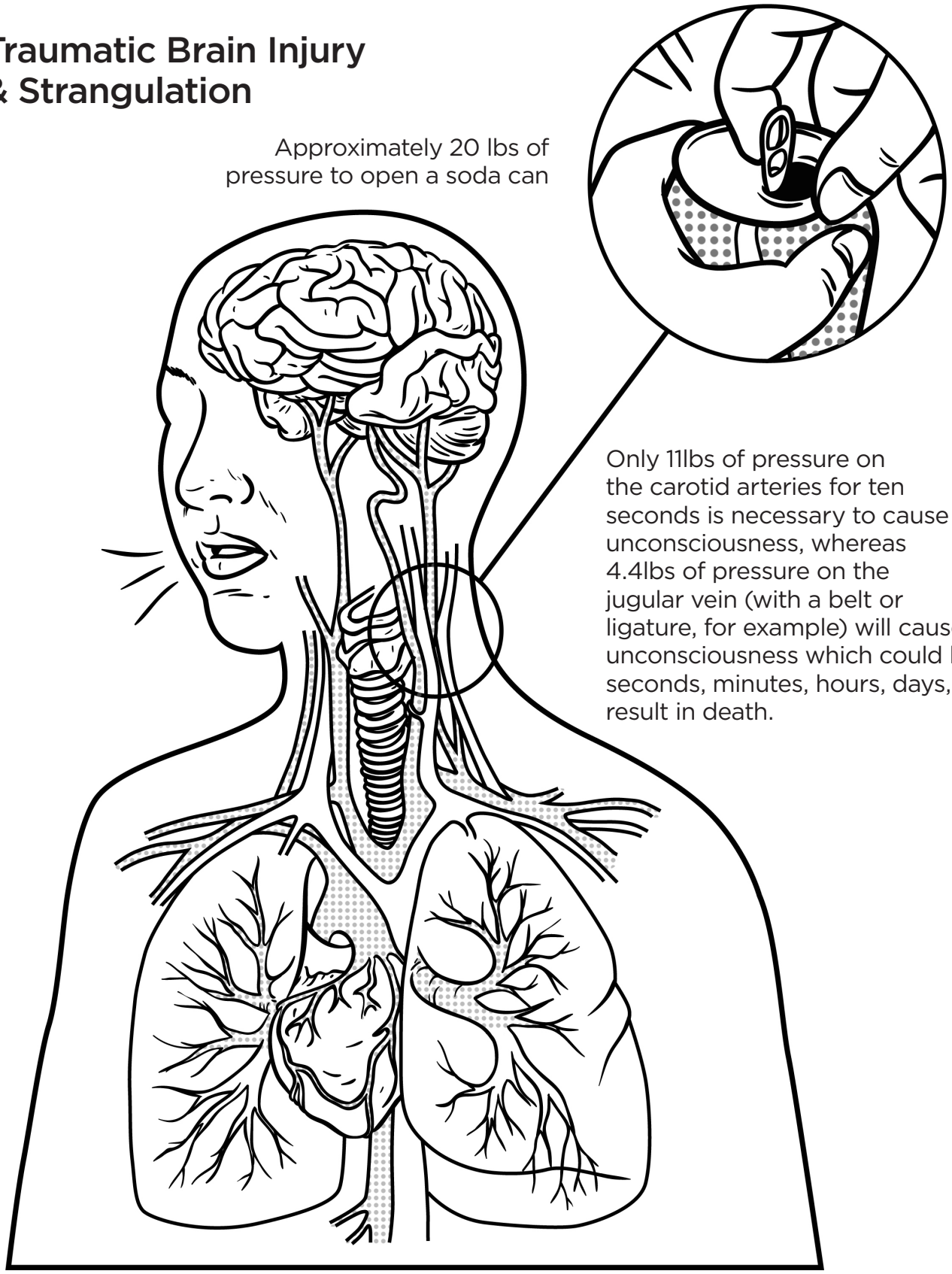
For women who have experienced physical violence, the most common sites of injury are the face, head, and neck. Attacks to this area are likely to result in injuries to the brain, however these injuries often go undiagnosed and untreated due to the lack of research and knowledge focused on TBI and violence within relationships. A woman can sustain a TBI without losing consciousness and may not have immediate obvious symptoms. No single test can confirm a diagnosis of TBI, or concussion, which is a type of TBI (Traumatic Brain Injury and Concussion, 2012-2017).

Injury to the brain can also result from strangulation or asphyxia – when oxygen is prevented from flowing to the brain by an outside force, even for brief periods with minimal force. Some resources such as the J. Campbell Danger Assessment use the language of "choking" as survivors often use this term rather than "strangulation". The trachea may also be restricted during strangulation and combined with asphyxia can quickly cause unconsciousness. A woman may seem fine after she is strangled, not fully recall the event, have no visible external injuries and still die days or weeks later due to tears in the carotid artery and respiratory complications like pneumonia and embolisms.

A woman who has been strangled is likely to be at high risk of physical harm and lethality from her perpetrator.

Traumatic Brain Injury & Strangulation

Approximately 20 lbs of pressure to open a soda can



Only 11lbs of pressure on the carotid arteries for ten seconds is necessary to cause unconsciousness, whereas 4.4lbs of pressure on the jugular vein (with a belt or ligature, for example) will cause unconsciousness which could last seconds, minutes, hours, days, or result in death.

Signs may include voice changes, difficulty/painful swallowing, hyperventilation, difficulty breathing, chin abrasions, scratches, abrasions, scrapes, redness/bruising on neck, petechiae (tiny red spots indicating ruptured capillaries), ligature marks, neck swelling, memory loss, and vomiting.

In particular, a woman who has sustained multiple TBIs throughout her life may experience impacts including: memory issues, headaches, fatigue, learning difficulty, decreased cognitive flexibility, general distress, depression, anxiety, irritability, problems with communication and other symptoms commonly associated with PTSD as a result of the trauma to her brain.

Concentration and impulse-control can be impacted. A woman with TBI might express emotion that doesn't match the situation she's in. Her vision and coordination might suffer. She could have seizures. One or any combination of these effects can interfere with her ability to escape a dangerous situation and access trauma related services.

It is difficult to distinguish between symptoms related to PTSD versus TBI and a woman may be experiencing symptoms related to both PTSD and TBI (Henderson, 2016). Navigating the overlap and interplay between PTSD and TBI can be especially challenging to a woman who lives with both conditions (Lash, 2018).

Though screening for TBI may not be within the scope of your position, recent research suggests a promising practice may include supporting survivors of violence as though they may have a TBI, even if there is no diagnosis. This involves repeating information, setting aside extra time for appointments, sharing information at a slow pace, helping the woman create personalized plans for carrying out follow-up tasks and offering reminders without judgement or frustration (Valdera, 2003).

Trauma and Concurrent Mental Health Issues

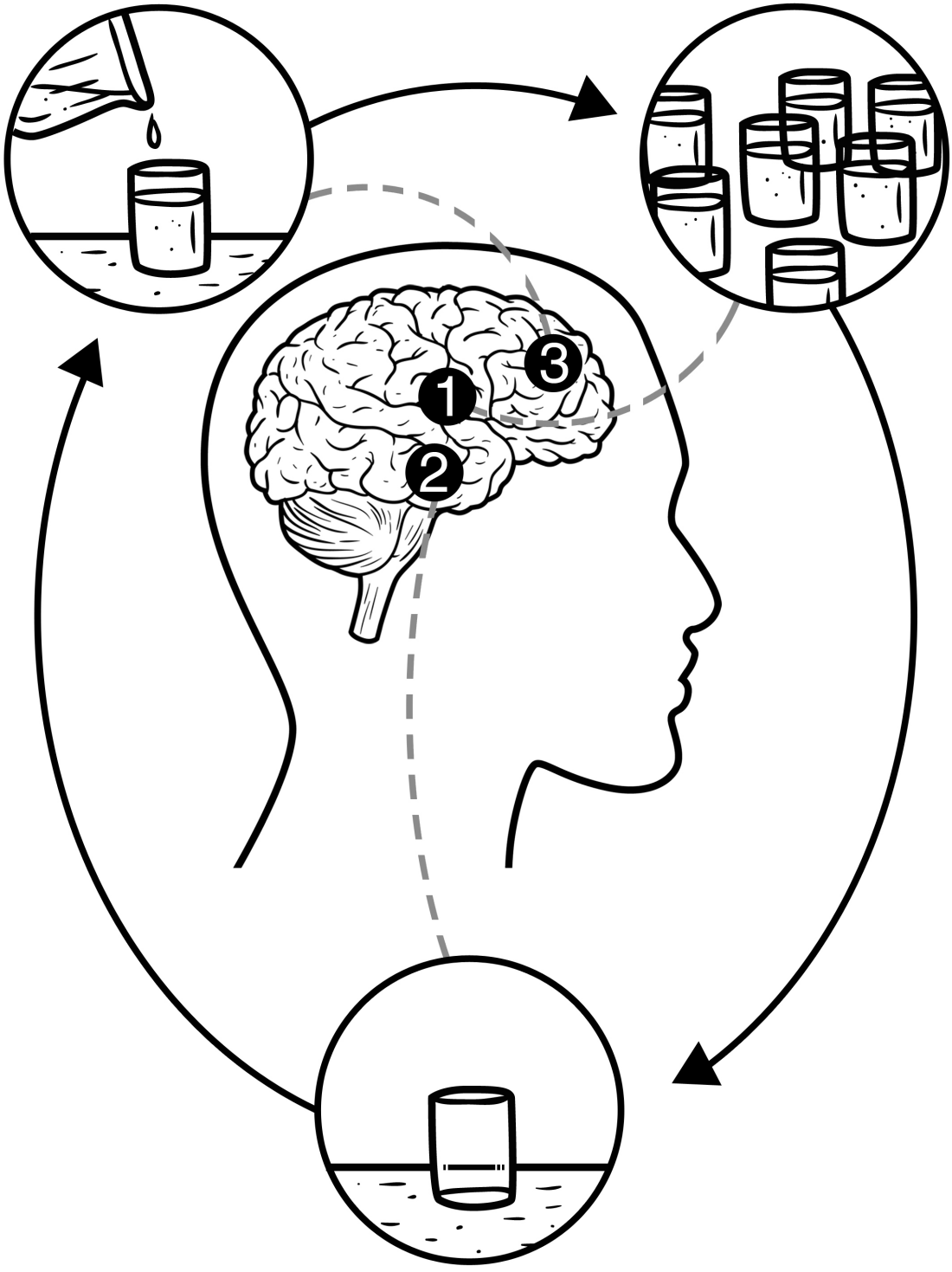
Substance use may increase an older woman's risk of experiencing further trauma, especially in certain locations and situatoins (Fairbrother, 2004). Harm reduction approaches focus on reducing risk while contextualizing a woman's choices related to substance use within the trauma and discrimination she has experienced throughout her life, and intergenerationally.

Anxiety: PTSD can go hand in hand with other anxiety disorders like generalized anxiety disorder, social anxiety disorder, panic disorder and obsessive compulsive disorder.

Depression: Research shows that close to half the people diagnosed with PTSD also suffer from or have suffered from depression (Tull, 2018).

Psychosis: Studies suggest that a significant proportion of psychotic disorders arise as a response to trauma, and that a woman can experience PTSD-like symptoms in response to having experienced psychotic episodes (Morrison, Frame & Larkin, 2003).

Substance Use & Trauma



Some women who have survived trauma use substances to cope with the impacts of trauma. Consumption of certain substances – including alcohol – causes the brain to release dopamine, a neurotransmitter that contributes to feelings of pleasure. Substances can offer a woman temporary relief from distress, but the relief comes at a high price. The woman may become dependent on substances; her substance use may lead her into situations where she is at risk of suffering further trauma.

Complicated Grief

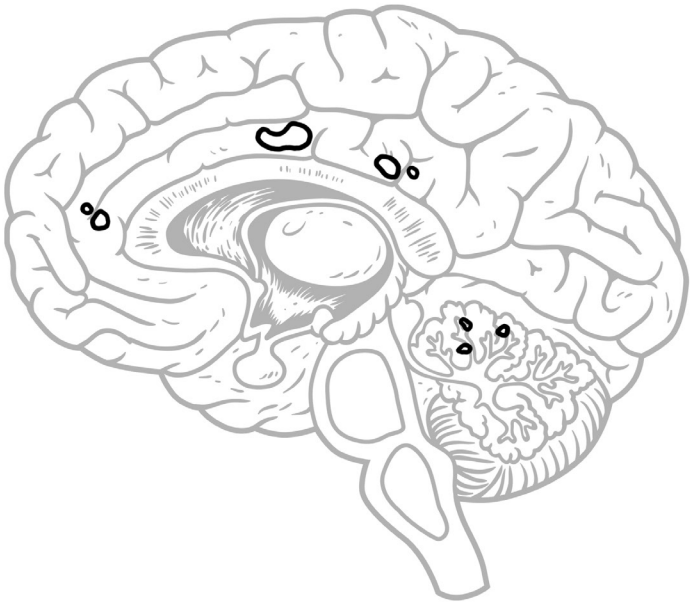
Grief is a shock that unfolds in phases – the immediate, acute pain of loss, and the extended mourning period afterwards. Grief activates the stress response and causes areas of the brain that regulate emotion to become underactive. In the immediate aftermath of loss, a woman might be tearful, sleepless, irritable. Her memory might suffer. Grief can compromise a woman's immune system so that she's more vulnerable to illness.

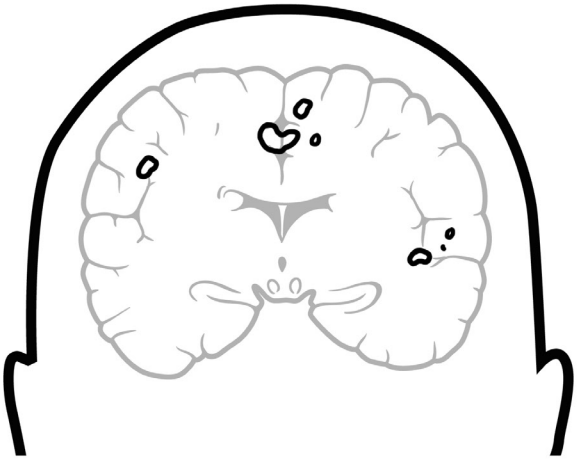
In the past, grief and trauma were mainly thought of as separate, but recent thinking sees them as entities that interact. **Complicated grief** (sometimes called **traumatic grief**) involves a bereaved person suffering from stress and despair that remain at acute levels for longer than a year. About 9% of older women who have been bereaved experience complicated grief (Shear et. al, 2014).

Complicated grief is debilitating. A woman who suffers from it will be preoccupied with intense yearning for the deceased person – yearning that impedes her ability to function in her daily life. Symptoms of complicated grief include: numbness; feelings of purposelessness and living in a fog; a sense that life is empty; a fragmented sense of trust/ security.

Heart pain is rooted in the brain

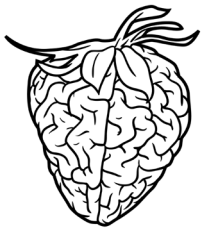
Neurobiological markers of complicated grief include higher than normal levels of the stress hormone **cortisol**, and greater activation of the **nucleus accumbens** (a key brain region involved in pleasure and addiction) when looking at pictures of the deceased person (O'Connor, 2019; Regehr & Sussman, 2004).





Heart Pain is Rooted in the Brain

Both survivors of trauma and women experiencing complicated grief may describe feeling as though their head is "in a fog."

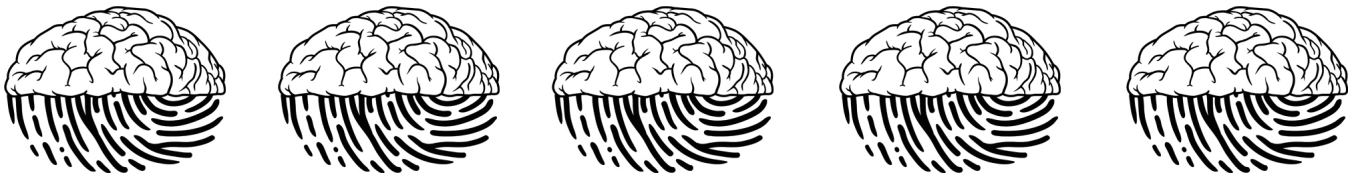


Food for Thought:

- What are some of the most comforting things people have said to you in times of loss? Try to remember the words and the way they were said. What words might you use to help comfort a grieving person?

Chapter 7
Intersecting Identities

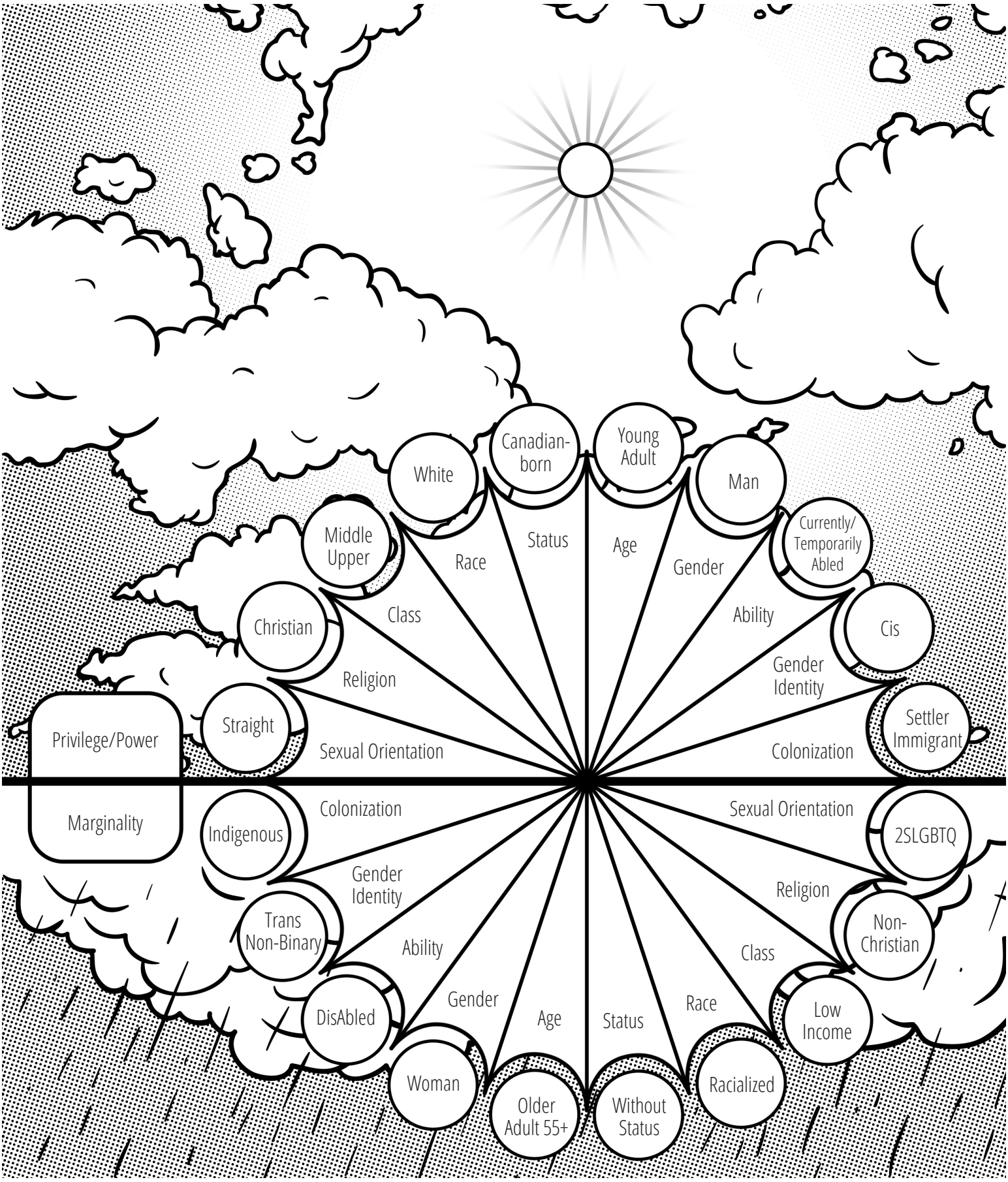
"Self reflection... is even more critical as we advance in our knowledge and understanding of oppression, power and privilege, intersectionality and how we ourselves hold both power and marginality, and we reinforce both oppression and marginalization, in our work, in our personal lives, with our family and anywhere we interact with others."
(How Does Intersectionality Work? OAITH, 2018).



To support an older woman who has survived trauma, it's important to consider the multi-dimensional nature of her identity and the oppression she's experienced. In doing this, you take an intersectional perspective. Intersectionality is an approach that encourages inclusivity and challenges the status quo. Intersectionality asks us to look at the ways that privilege and disadvantage influence a woman's experience of trauma as well as our own identity and related privilege and marginality (Intersectionality, 2015).

This intersectionality wheel can be utilized to explore intersecting identities. What groups (cultural, socioeconomic, racial, religious) does the woman belong to? What types of societal oppression have shaped her life? What groups do you belong to? What are your privileges and disadvantages? How do both, your, and the woman's histories influence the meeting between the two of you?

Intersectionality Wheel



Indigenous Women

Indigenous women in Canada have been collectively traumatized by government-endorsed racism. They have been confined to reserves, separated from their families, and forced to attend residential schools where physical and sexual violence were perpetrated by staff (Intervention to Address Intergenerational Trauma, 2012). The abuses an older Indigenous woman may have encountered, are examples of Systemic Trauma. Systemic Trauma is inflicted and maintained by environments and institutions. It includes the oppressive actions of schools, communities and cultures (Goldsmith, Martin, Smith,2014), such as the Canadian government's attempt to assimilate Indigenous peoples.

An Indigenous Intersectionality Framework or "Red Intersectionality" is centered in a commitment to activism and Indigenous sovereignty and contextualizes the violence against Indigenous women and girls within gendered colonization and dispossession of Indigenous lands. This analysis includes identifying strengths and resistance to oppression and violence and might include some of the following questions (adapted from Clark, 2016):

- How are your client's experiences of trauma and coping framed or pathologized in the current health, metal health, justice, and social service systems?
- How can her experiences and identity be understood within the context of colonialism, poverty, racism, and discrimination?

Smudging

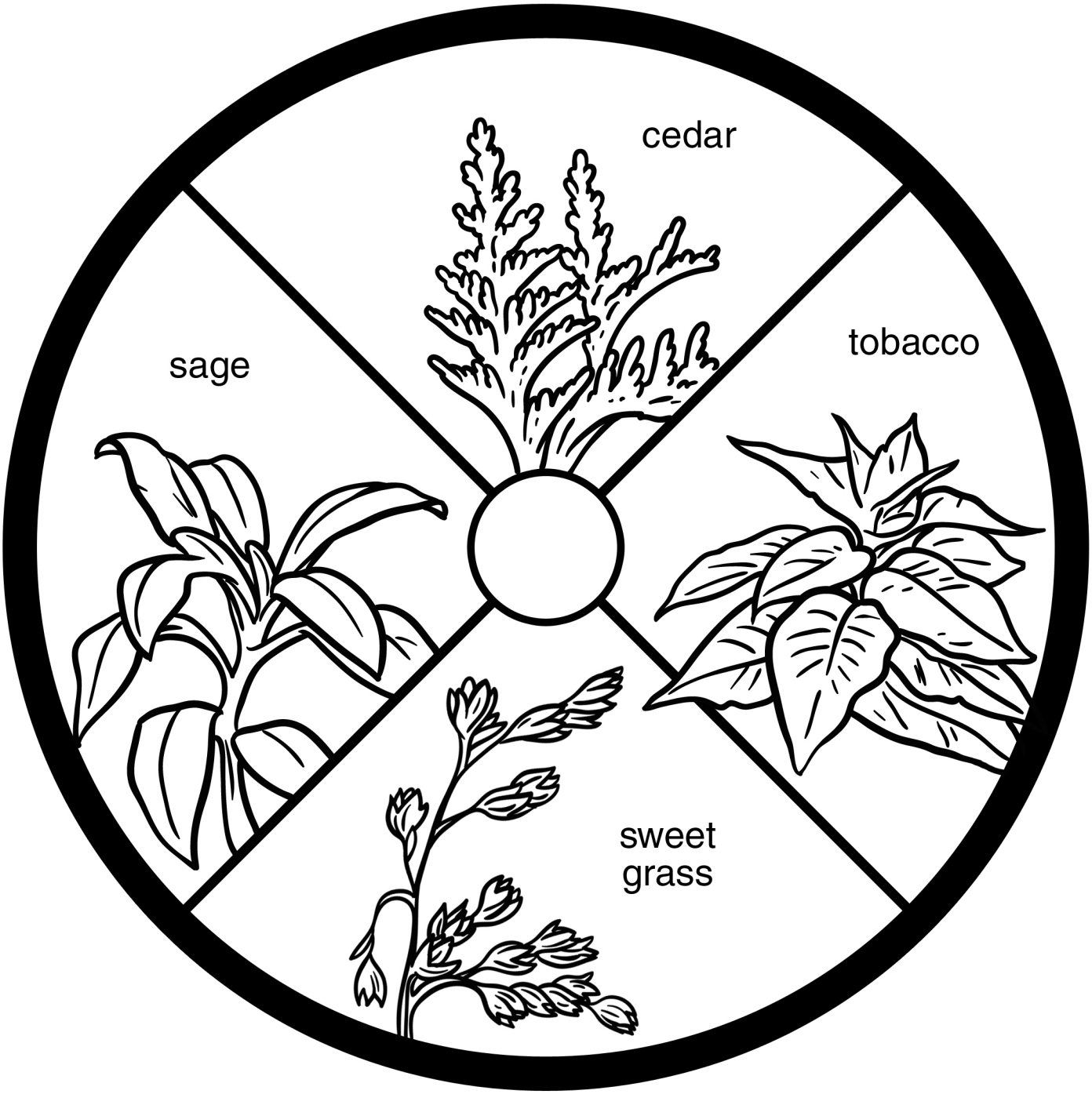
Organizations and services in Ontario which are under provincial jurisdiction have a responsibility and duty to understand and accommodate Indigenous beliefs and spiritual practices, including smudging. Smudging is a common purification ceremony or rite performed by many Indigenous and non-Indigenous individuals or groups and involves the burning of any of the four sacred medicines; Tobacco, Sage, Sweet Grass, and Cedar, in a shell or wooden bowl to produce a cleansing smoke. Not every Nation across Turtle Island (North America) smudges, or smudges in the same way. Smudging is often used first thing in the morning, during a meeting or event and when someone is facing barriers; a woman may need to smudge at unpredictable times, for example, following a trauma or before or after a difficult interview or meeting related to violence she has experienced (NWAC, 2014).

Smudging Within Services– Promising Practices

(adapted from NWAC)

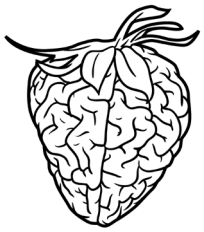
- Ensure transparent protocols and inclusive design measures to facilitate smudging in an appropriate, dignified and timely way, without advance notice needed;

- Facilitate an indoor space for smudging and other traditional ceremonies, access to/storage for traditional medicines, and clean water;
- Connect with traditional elders and healers in your area;
- Educate staff about smudging and other Indigenous ceremonies.



An intersectional approach involves sensitivity to systemic trauma. As someone who works with trauma survivors, it's important to acknowledge that every woman encompasses a multiplicity of circumstances, and that you do as well; Part of your work is to consider your own circumstances and how they affect your relationship and interactions with the woman.

> Trauma-informed practice allows for the creation of a safe space in which to address colonization, oppression, intergenerational trauma and racism. It makes room to discuss Indigenous-specific issues and concerns. Trauma-informed practice compliments and honours Indigenous values and beliefs.



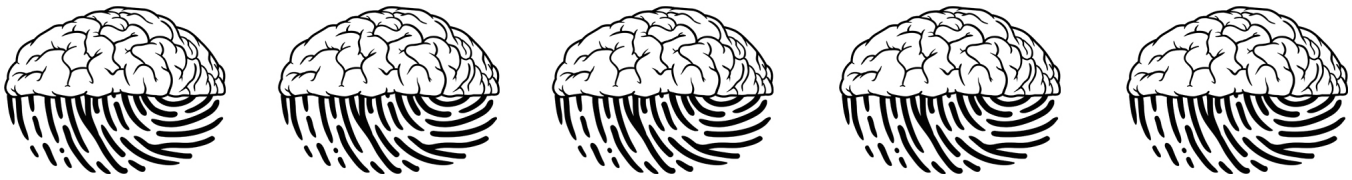
Food for Thought:

- What cues might indicate to a survivor that you are supportive and inclusive of diverse gender and sexuality identities?
- How might an older immigrant or refugee women's dependency on family members affect her access to housing supports?
- What identities are missing from the categories on the intersectionality wheel?

Chapter 8
Trauma, Memory, and Narrative: Providing Support During Disclosures and Interviewing Survivors of Trauma

"(Survivors) often are not equipped to explain their own psychological responses and coping. They may not recognize the role of abuse-related trauma in the development of some of their own severe responses and ways of managing. What might appear as "inconsistencies" in the way a victim reacts or tells her story in a service context or a legal proceeding is actually very often a typical, predictable, and normal way of responding to life threatening events and coping with and remembering traumatic experiences."

– (Haskell, L. Trauma-Informed Approaches to the Law, 523)



Understanding what happens in the brain of a woman who has survived trauma will help you to interview and support in a way that's compassionate, non-judgemental, and effective. Survivor responses that are commonly mistaken for deception can be explained by the neurobiology of trauma.

Traumatic events and the breakdown of narrative

Memory is a complex process with a variety of factors affecting how an experience is encoded, consolidated, and stored in our memory, along with information that provides context, such as time and place. In order to tell a story about what we have experienced we must recall the information and place this into a sequence which makes sense to us. A traumatic experience is like a collection of puzzle pieces that may not fit neatly together into a narrative for the survivor or her interviewer or service provider.

Often, professionals trying to understand the events surrounding trauma may focus their questions around sequences of events: What happened next? And after that? And

after that? However, the woman might not be able to put her assault into a narrative with a clear beginning, middle, and end. She may not remember some parts of the assault at all. This is a protective response, and one that can be better understood by considering that, during an assault, a woman's brain chooses how to respond, and how to encode the memory of the assault.

When a woman is attacked, she goes into defense mode and her ability to control her attention is compromised. Her defense circuitry overrides her thinking brain and her survival instincts take over until the threat has subsided. While a woman is in defense mode, her brain may choose to focus on a seemingly insignificant detail as a mechanism of survival, while blocking out other details. The things a woman focuses on during an assault are **central details**. Anything else is a **peripheral detail**.

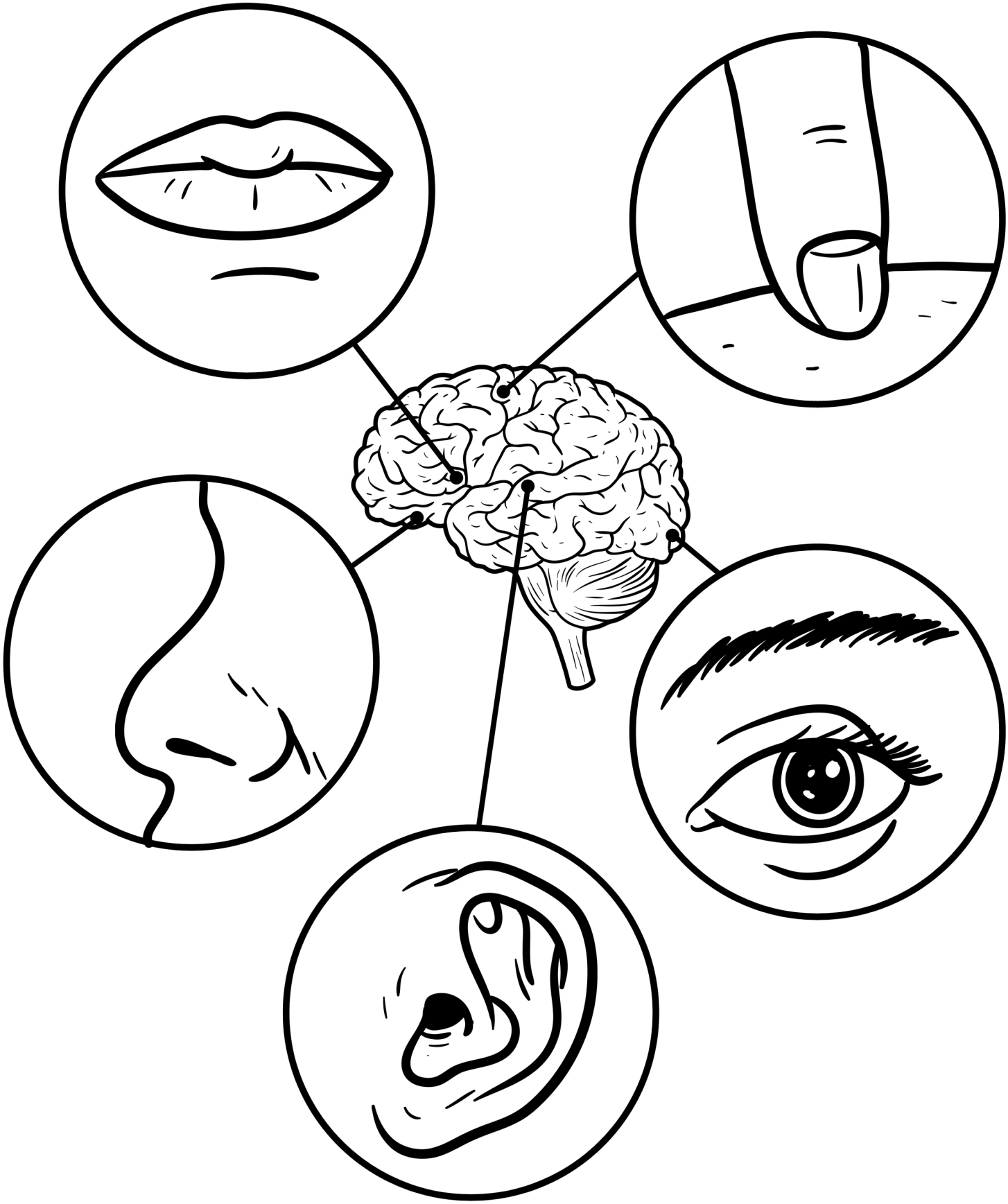
We can't predict which details of an attack will be **central** and which will be **peripheral**. A woman who is being assaulted might focus on a lamp in a corner; a crack in the ceiling, or the number of ceiling tiles. Sometimes the woman won't recall a notable feature of her attacker's appearance – a large facial tattoo, for example, in one case– because her attention was elsewhere.

Within the context of a criminal investigation, asking what a survivor smelled, heard, saw, felt, and tasted may uncover new puzzle pieces of memories, especially if a survivor is not asked to think about details in a particular way (often linear) but asked to share further sensory details. Survivors may blame themselves for not being able to recall certain details, so reminding a woman her brain chose what to remember may be helpful.

Any clarifying questions should be left until the end of the interview or disclosure. You can ensure a space is comfortable by considering inclusive, accessible designs, and ensuring water and tissues are available.

A woman may recall the initial moments of an attack vividly yet have only fragmented memories of the rest of the attack. At the onset of an attack, the hippocampus goes into "overdrive," encoding as much data as it can. After about thirty seconds, the hippocampus enters another mode where it aims to process information from those first thirty seconds. In the second mode, the hippocampus doesn't have the resources it needs to encode sequences of events. Anything that gets encoded to memory later in the attack will likely be stored as a **fragment** or island of sensory detail– a sound or smell for example – that exists out of context. (Wilson, Lonsway, Archambault, 2016).

Fragments of memory may be triggered by any of the 5 senses: smell, touch, taste, sight, or sound.

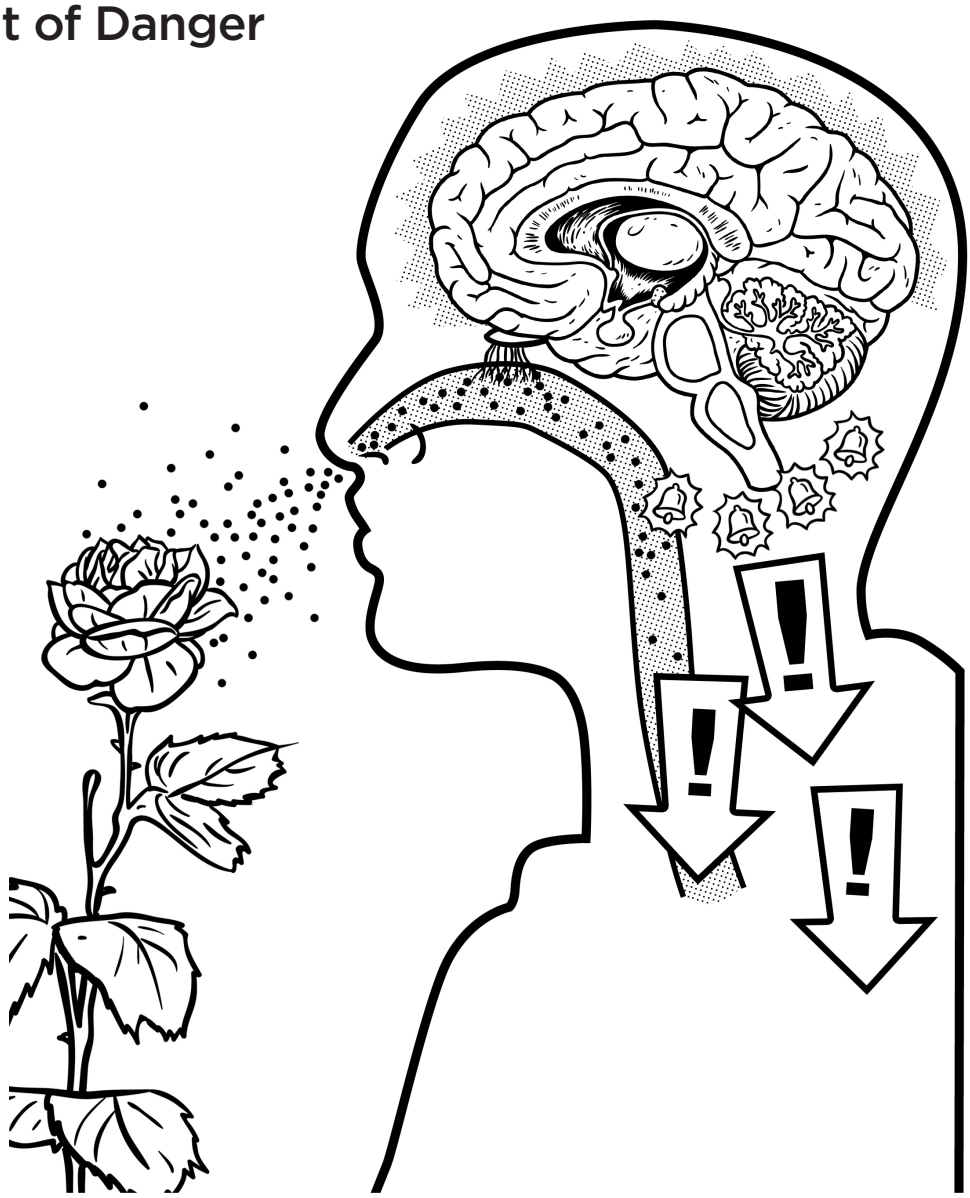


Scent, Trauma, and Age

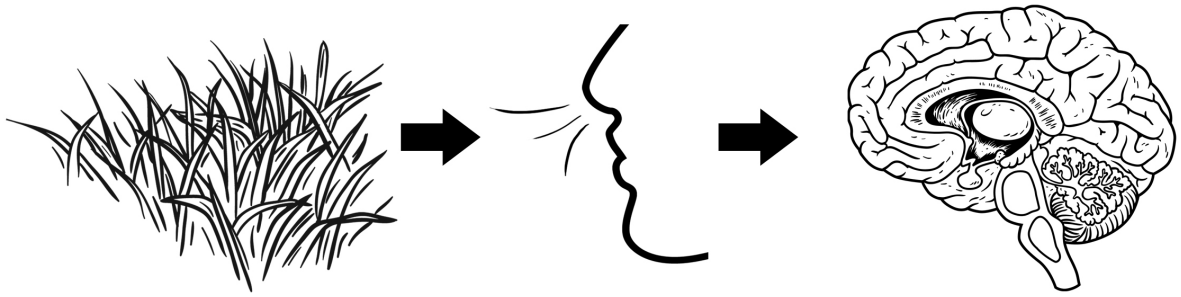
Smells are powerful, quick-acting cues to our brains and bodies. Women who have survived trauma are often triggered by smells. Illness, injury and aging can change or compromise a woman's sense of smell. Odors are one of the most potent reminders of past trauma and can play a key role in various forms of treatment (Cortese, et al. 2016), and in particular, exposure-based therapies (Morrison et al. 2015). It's important to consider the impact of aging and trauma on olfactory senses; anosmia is the temporary or permanent loss of sense or smell, and can be caused by head trauma, neuro-degenerative diseases, brain tumors, as well as changes in mucus composition associated with aging.

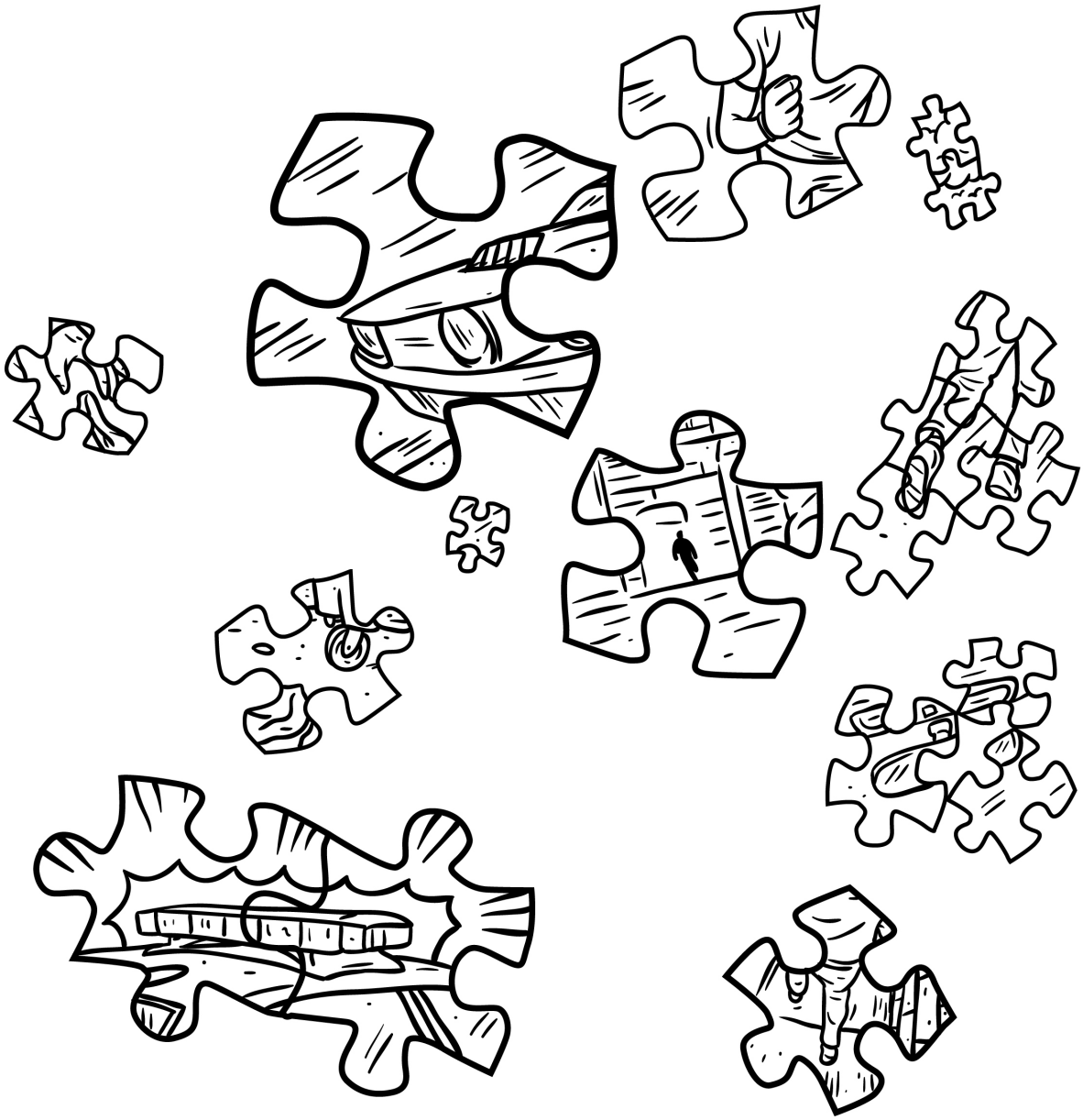
At the First Scent of Danger

Trauma survivors may be triggered by smells, for example, a woman who was often given roses by an abusive partner following sexual and physical assaults as part of an apology may experience flashbacks when she smells flowers, even decades after the violence has ended. This smell can cause her amygdala and hippocampus to set off a high alert alarm throughout her nervous system, increasing her heart rate and breathing as the smell of roses is now linked with fear of harm. As the conscious brain processes the stimuli, the subconscious awareness of danger now becomes the conscious emotion of fear (LeDoux, 2015).



Traumatic memories are often a puzzle which does not fit neatly together. After a high-speed chase resulting in a fatality, an officer who experienced secondary or vicarious trauma, may not recall how long the chase lasted or other key details. Islands of memory may be triggered by sensations, such as the smell of fresh cut grass, but the ability to track time and distinguish minutes from hours is impeded during times of extreme stress. Avoid asking a trauma survivor questions she is unable to answer, such as how long a specific part of an assaulted lasted, as this can increase her sense of shame, blame, and confusion, related to the experience.





Explaining the Neurobiology of Trauma to a Client

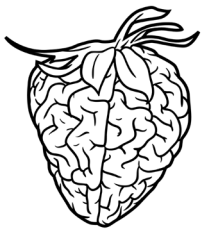
Living with trauma – the memory or lack of memory of it, the physiological and psychological effects – can confuse, frustrate, and frighten a woman. It may be beneficial for you to explain parts of what you know about the neurobiology of trauma to a client. It might help her to feel less alone, less a stranger in her own body. If you do decide to share some of what you know, try to communicate simply and clearly. Check in often with the woman to see if she's understanding what you're telling her, and to make sure she wants the information you're offering. Look at the interaction not as a lesson, but as an opportunity to connect.

How can you apply this information to your interviewing technique? Here are some guideposts:

- Postpone the interview until the woman has had at least one and preferably two sleep cycles following the assault. This allows the woman to rest, regain cognitive resources, and encode details vital to the interview. (Archambault & Lonsway, 2019).

- Try to imagine how it feels to be the woman you're interviewing. Think about the stress the interview puts on her. That stress alone could get in the way of her remembering things. Do your best to make the woman feel accepted and believed.

- Remember that a woman who has been assaulted will probably not be able to put the attack into a sequential narrative. Instead of asking "what happened when?" questions, ask open-ended questions that focus on sensory experiences. What does the woman remember seeing, hearing, smelling, touching during the attack? A bit of sensory information might be a useful clue in its own right. It might also prompt the woman to recall more information.

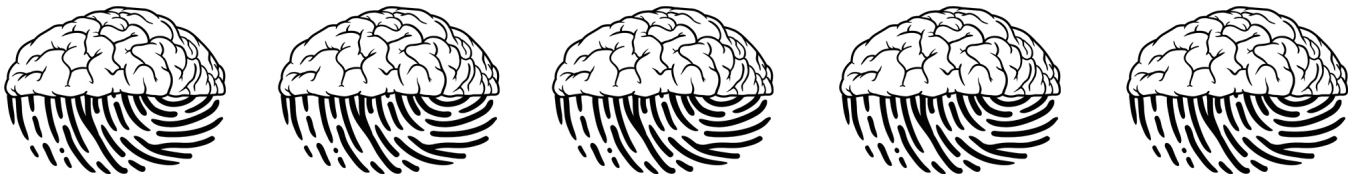


Food for Thought:

- What policies exist in your workplace to support trauma-informed approaches?
- When working with trauma survivors, how could you, your workplace or programs integrate questions and information related to scent-based trauma triggers?

Chapter 9
Vicarious Trauma

"...trauma brings both strengths and problems. Common, albeit not invariable, strengths include the development of profound survival skills, an enhanced ability to understand other traumatized and oppressed individuals and groups, a passion for justice, a desire for a different kind of society, a certain critical realism, and what is particularly significant, a less distorted view of the world."
(Burstow, 2003)



Service and care professionals who work with trauma survivors may find their own well-being negatively impacted by the intensity of their work. When this happens, we say the professional is experiencing **vicarious or secondary trauma**. Vicarious or secondary trauma can have significant impact on a service provider, affecting their sense of identity, relationship with others, their work, and their perspective on trauma, core beliefs and the world in general. Symptoms of vicarious trauma might include: intrusive imagery, nightmares, fear for one's personal safety, difficulty listening, irritability, emotional and physical depletion or numbing, and hopelessness. In the same way that trauma-informed approaches for clients promote the de-individualization of responses to trauma, research suggests that vicarious trauma is best addressed structurally rather than individually, to mitigate traumatic exposure to any one worker by effectively distributing workload (Bober & Regehr, 2006).

Workers experiencing compassion fatigue, vicarious trauma, or moral stress may develop symptoms after just one case, with a rapid onset of symptoms, however they may desire to continue to help trauma survivors. (Figley & Figley, 2007). Tools which help to distinguish between and measure **compassion fatigue**, include the Professional Quality of Life Scale: Compassion Satisfaction and Fatigue Subscales (ProQOL).

Risk factors for vicarious trauma include work overload, lack of reward or acknowledgement for work, lack of peer support, and insufficient opportunity to debrief. Employers can help to prevent vicarious trauma by recognizing and respecting workers, encouraging open communication, ensuring adequate supervision is available, and providing employees with various types of support (Lumor, 2017).

Ultimately, long term work with trauma survivors changes the way we view ourselves, and the world. We may feel less safe in society as a result of the awareness of violence (both individual and systemic), and frustration, anger and disbelief at the responses or lack of responses from services and systems. Advocacy for systemic change can be an important component for any professional who works with women who have experienced violence.

Warning Signs of Vicarious Trauma/Compassion Fatigue/ Burnout/Moral Stress

Worst case scenario thinking patterns

Reacting disproportionately

Difficulty taking vacation time

Loss of job satisfaction

Decreased effectiveness in your professional role

Physical pain and insomnia

Anxiety, depression

Feelings of isolation (friends, family, co workers)

High risk behaviour

Victim-blaming attitudes, language, and actions

Steps towards healing and balance for service providers of trauma survivors

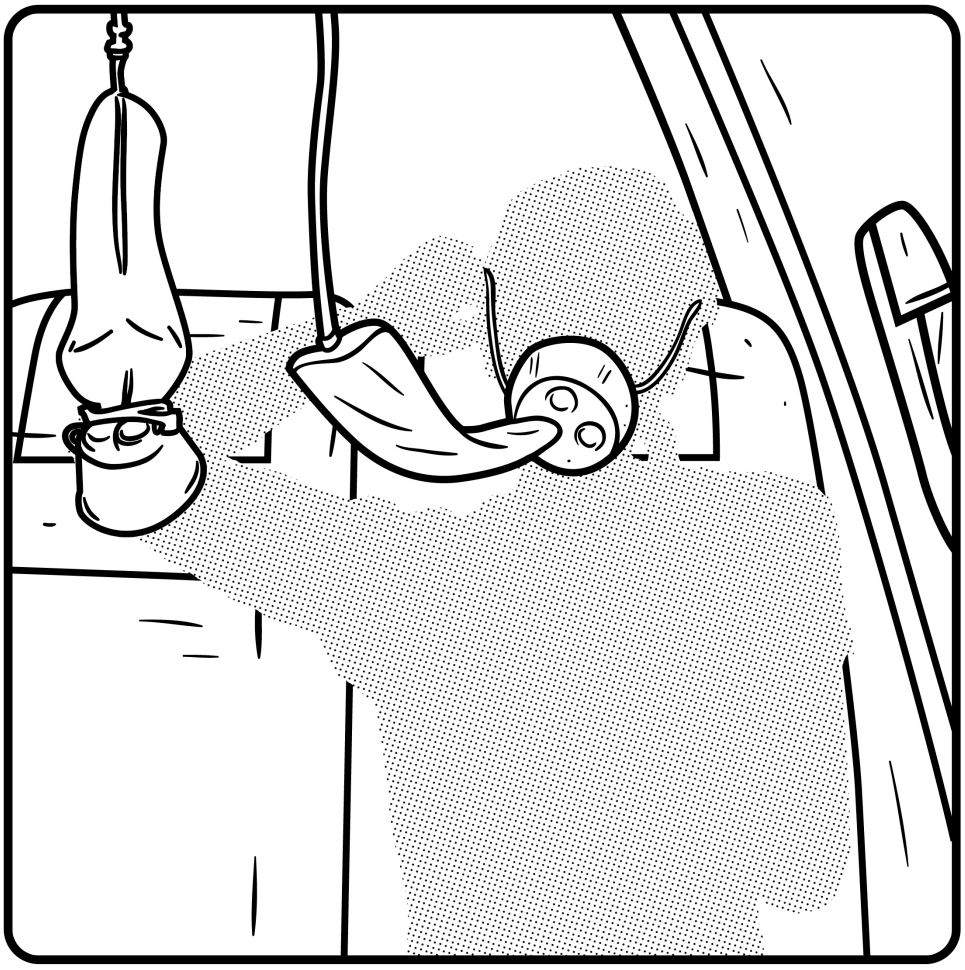
Caseload balance

Self care reflection and practices

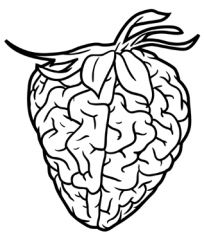
Increasing support and knowledge base

Working towards systemic change

Putting Your Own Mask on First



Professionals who work with survivors of trauma are often reminded to "put their own oxygen mask on first" which can also be a useful analogy for promoting self-care and self-prioritization with women who have experienced trauma and may have been socialized, pressured, or forced to deprioritize their needs over children, family members and partners. This analogy refers to the safety instructions provided by flight attendants during air travel: if you have a dependent with you, during an emergency, ensure you put your own oxygen mask on first as this will allow you to stay conscious and help those around you. Ultimately, we can not help others without first prioritizing ourselves and our short- and long-term wellbeing. This analogy is also helpful in promoting self-care and preventing caregiver burnout for those who may be in a caregiving role to an older woman with complex needs.

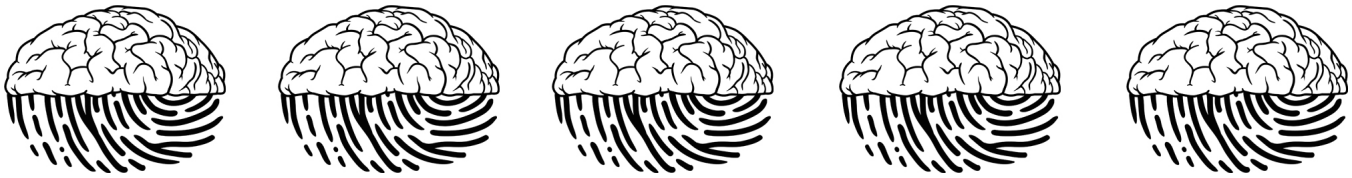


Food for Thought:

- How has your work with trauma survivors changed the way you view the world?
- What have you found helpful in tracking and addressing the impacts of trauma work within your field?
- What are the barriers to accessing support and help as a professional?

Chapter 10
Towards Hope, Resiliency, Resistance and Healing

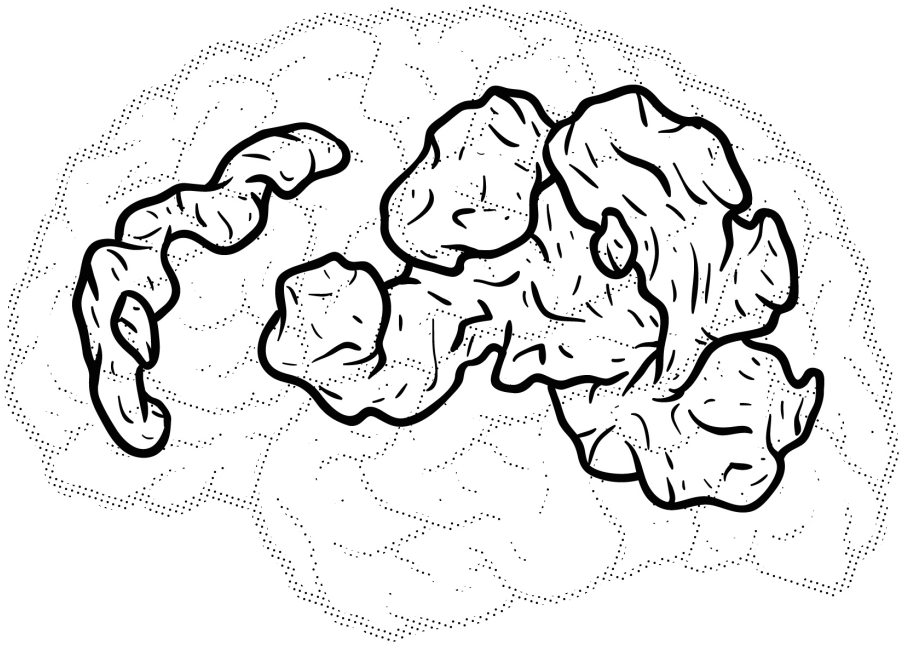
"A healing centered approach to addressing trauma requires a different question that moves beyond "what happened to you" to "what's right with you" and views those exposed to trauma as agents in the creation of their own well-being rather than victims of traumatic events."
(Ginwright, 2018)



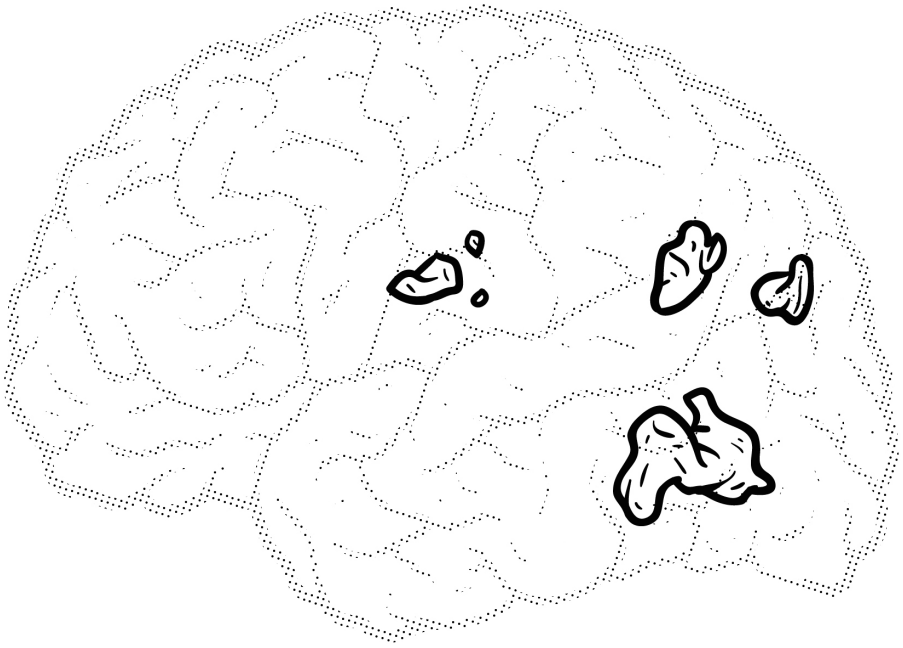
As you've read, the brain is remarkably adaptable – constantly altering its composition and function in response to what it encounters. That adaptability shapes a woman's experience of trauma. It can also allow her to find relief – relief that may have eluded her for years. Our brain exists in networks, just as we do. Yes, trauma changes the brain, but, so does empathy (Jankowiak-Siuda, Rymarczyk, Grabowska, 2011).

Intersectional approaches to healing honour and explore valuable concepts of recovery, resiliency, and resistance beyond traditional Western approaches. Western approaches of "wellness" are focused on the absence of illness while Indigenous wellness may centre around physical, mental, emotional and spiritual balance and the bond between self, others, and the environment (Linklater, 2011). Approaches to healing within some Indigenous communities emphasizes the importance of storytelling, and the receiving of stories, as an act of resistance to oppression and violence. Storywork including poetry, story telling and song can be a powerful part of healing by creating community and generating new meaning out of personal and collective experiences (Clark, 2016).

Activated Brain Regions Prior to EMDR



Following EMDR

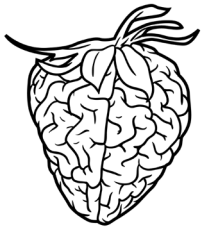


Researchers and practitioners can now measure the impact of therapeutic treatments by scanning the brain before and after treatments. The top image shows a brain with many areas which are overactive and may cause emotional dysregulation, flashbacks, feelings of numbness and cognitive fogginess and nightmares. The bottom image was taken after a series of EMDR (Eye Movement Desensitization and Reprocessing) therapy sessions, showing a reduction in overactivity. Numerous studies indicate the potential of treatments such as EMDR in affecting the function of the thalamus in particular, which can eliminate if not significantly reduce symptoms associated with PTSD. (Bossini et al, 2017).

Grounding Techniques

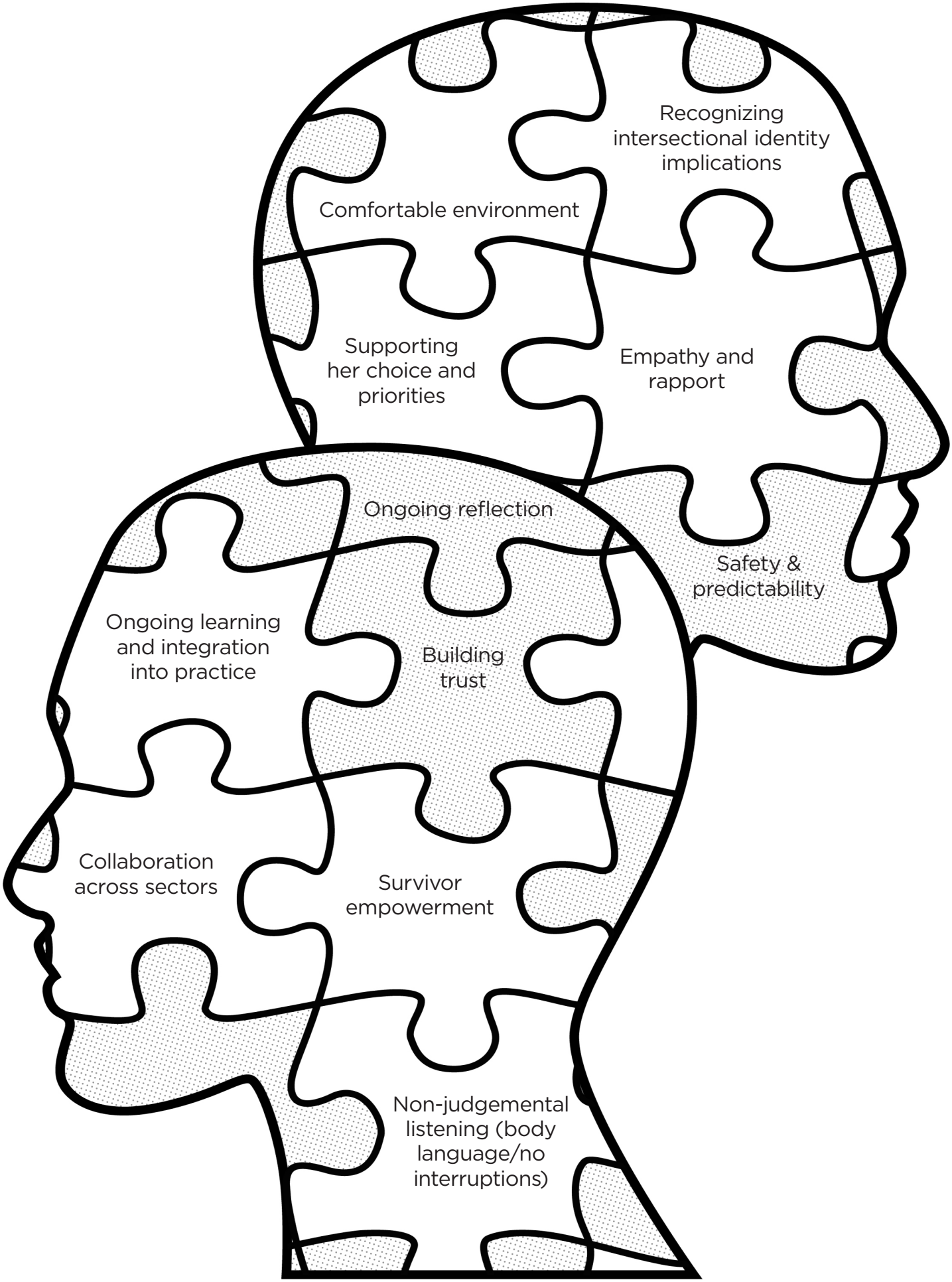
Grounding is a strategy meant to connect a woman to her immediate environment by utilizing her senses – sight, hearing, smell, touch, taste. It can be a helpful way for to manage flashbacks, high anxiety and dissociative symptoms. Grounding strategies include listening to music, ten or more deep cleansing breaths, running your hands in cool water, touching the earth, and tasks that involve repetition or focus such as a crossword puzzle.

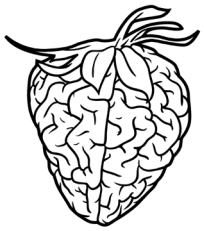
A healing kit or bundle (or medicine bundle) may consist of one positive item connected to each of the five senses which can help to calm "high alert" responses, for example, a smooth stone to touch and sage to smell.



Food for Thought:

- What coping strategies have you noticed in older women who have experienced violence? How can these strategies be understood in the context of the intersections of her identity? (gender, age, sexuality, race, ability, etc.)
- What specific resources are available near your community for women with unique barriers who are experiencing trauma? This may include older women, women with disabilities, Indigenous women, racialized women, and immigrant and refugee women.


Recognizing intersectional identity implications
Comfortable environment
Supporting her choice and priorities
Empathy and rapport
Ongoing reflection
Safety & predictability
Ongoing learning and integration into practice
Building trust
Collaboration across sectors
Survivor empowerment
Non-judgemental listening (body language/no interruptions)



Food for Thought:

- What does predictability, transparency, and collaboration mean for your sector? How do you share information about recordkeeping with survivors?

- Is the space where you meet with survivors accessible physically and culturally to older women? How could you modify this space to feel safer and more welcoming to an older, trans, Indigenous woman with a brain-injury?

- What was the most impactful part of this tool for you? How might you share this with other professionals in your field? Which concepts might be more difficult than others to integrate into your work?

Post Test Cue: Please visit https://www.oaith.ca/visual-training-quiz.html to complete a brief quiz related to the material you have learned.

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