



aneemo



Expert Webinar Series: Applying Trauma Informed approaches

Dr Emma Williamson
Consultant Clinical Psychologist
Founder CEO



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Dr Emma Williamson

Consultant Clinical Psychologist
CEO aneemo

- Founder **aneemo** staff training platform – backed by government
- Founder / Clinical Lead - multi-award winning homeless psychology health care innovation at South London & Maudsley NHS
- Government advisor,
- Organisational & Systems Change consultant
- Author and national good practice development lead
- International speaker and trainer
- Visiting doctoral lecturer at Kings College London, and other Uni.



Passionate about systems change, helping organisations working most effectively with those who need it most



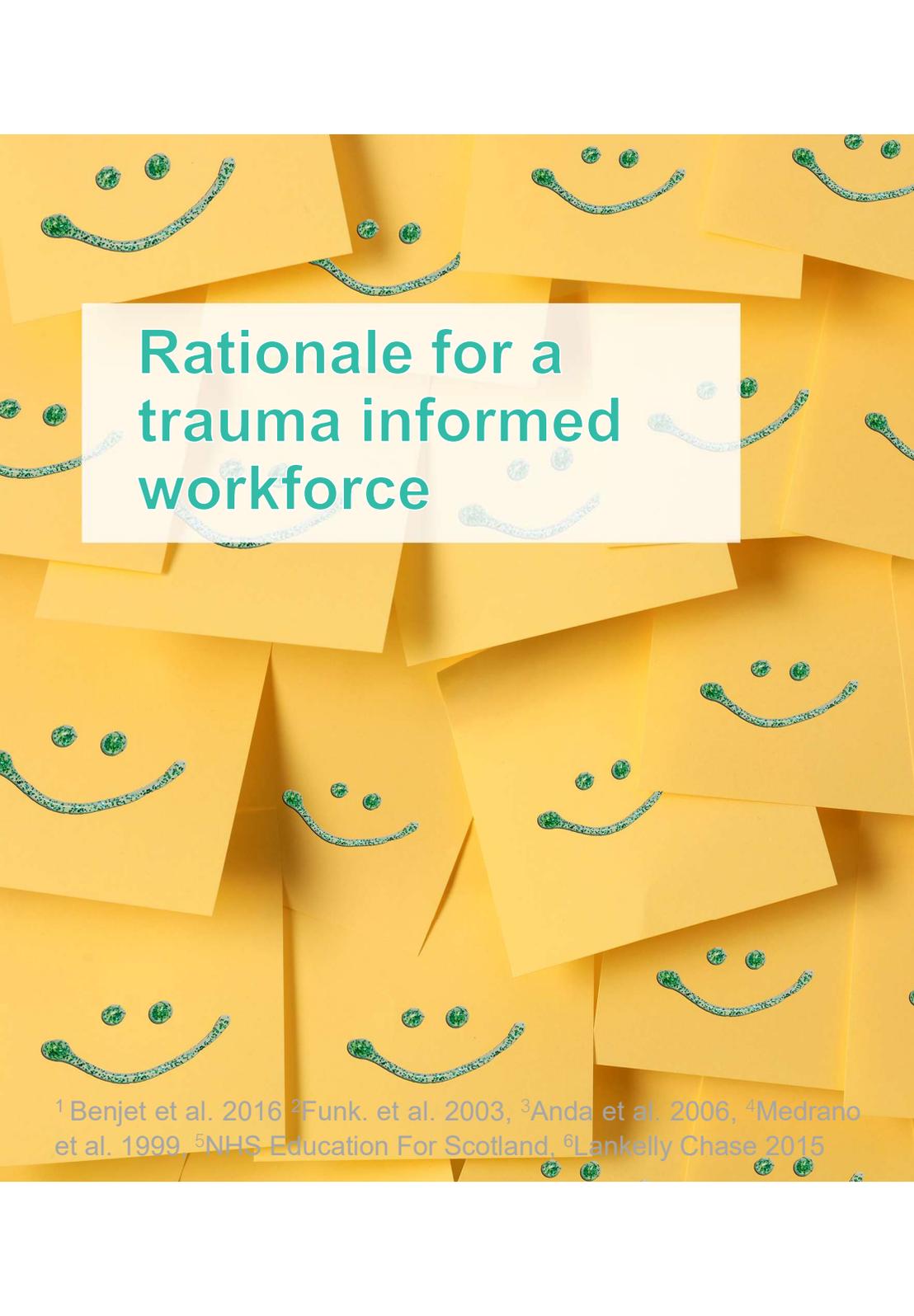
Innovate
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The British
Psychological Society
Promoting excellence in psychology

Psychological Safety





Rationale for a trauma informed workforce

¹ Benjet et al. 2016 ² Funk. et al. 2003, ³ Anda et al. 2006, ⁴ Medrano et al. 1999. ⁵ NHS Education For Scotland, ⁶ Lankelly Chase 2015

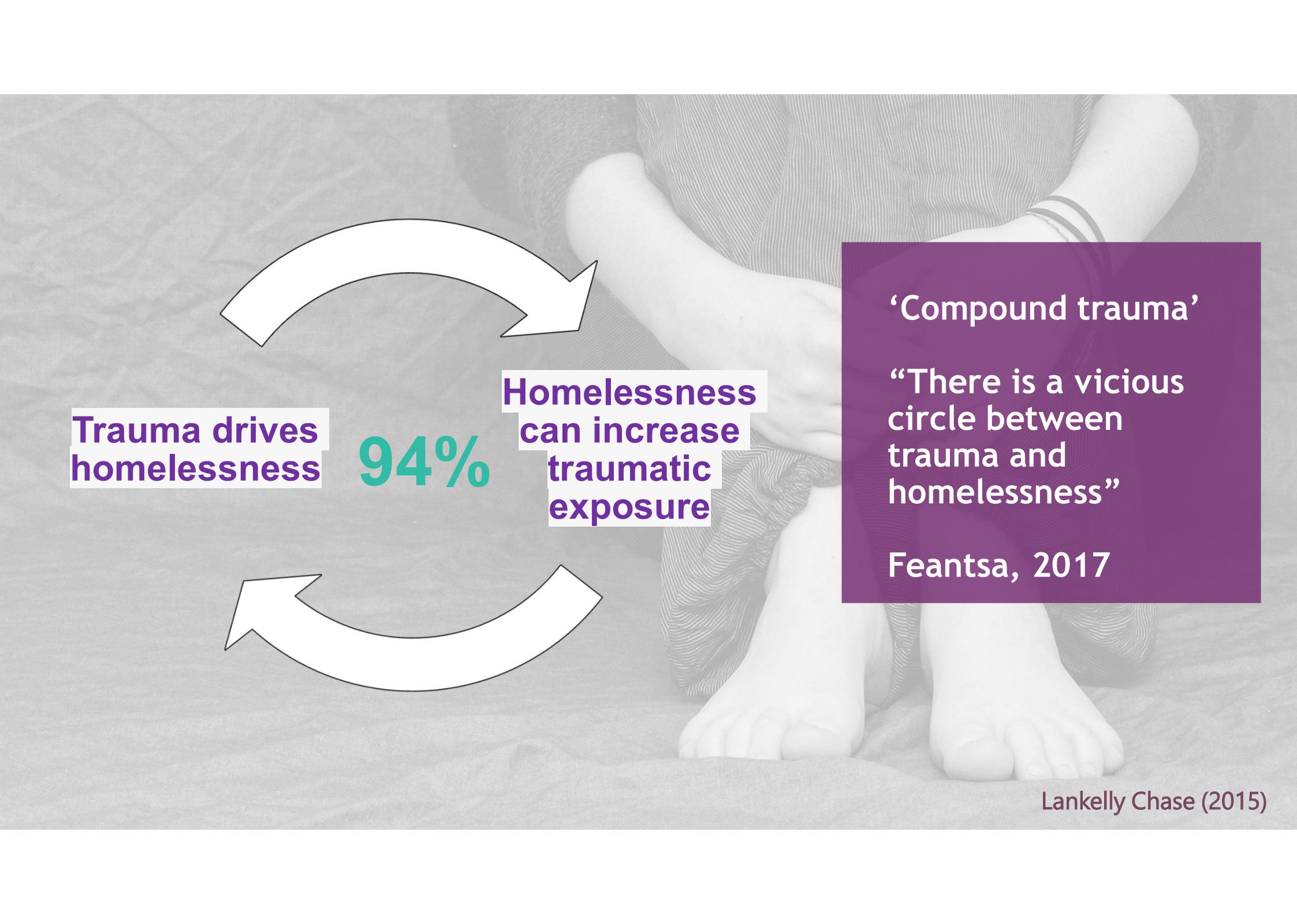


- Highly relevant to our lives and work
- Worldwide estimates 70% ppl experience 1+ trauma
- 31% = 4+ traumatic event in lifetime
- Prevalent in multiple disadvantage
 - 94% prison childhood trauma
 - 94% homeless people report trauma
- Workforce Impact well documented
 - 30% sickness absence in social care = stress/mental health
 - £51bn UK employer cost of poor MH
 - 1.65m lost FTE days in councils (22–23)



1

The Theory of Trauma



Trauma drives homelessness

94%

Homelessness can increase traumatic exposure

‘Compound trauma’

“There is a vicious circle between trauma and homelessness”

Feantsa, 2017

Impact of Trauma

- When someone experiences trauma or retraumatization, their nervous system reacts as if in danger.
- This can trigger automatic survival responses — fight, flight, freeze, fawn, or flop.
- The thinking brain (prefrontal cortex) goes offline, and the survival brain (amygdala and brainstem) takes over.



Adverse Childhood Experiences (ACEs) can affect our –

- **Physical and mental health**
- **Emotional and cognitive functioning** (*how we think, feel and communicate*).
 - how we remember things, problem solve, reason and make decisions
- Our **social functioning incl.**
 - how we build relationships, manage emotions and behaviour
 - how we seeking care, access support and engage with services

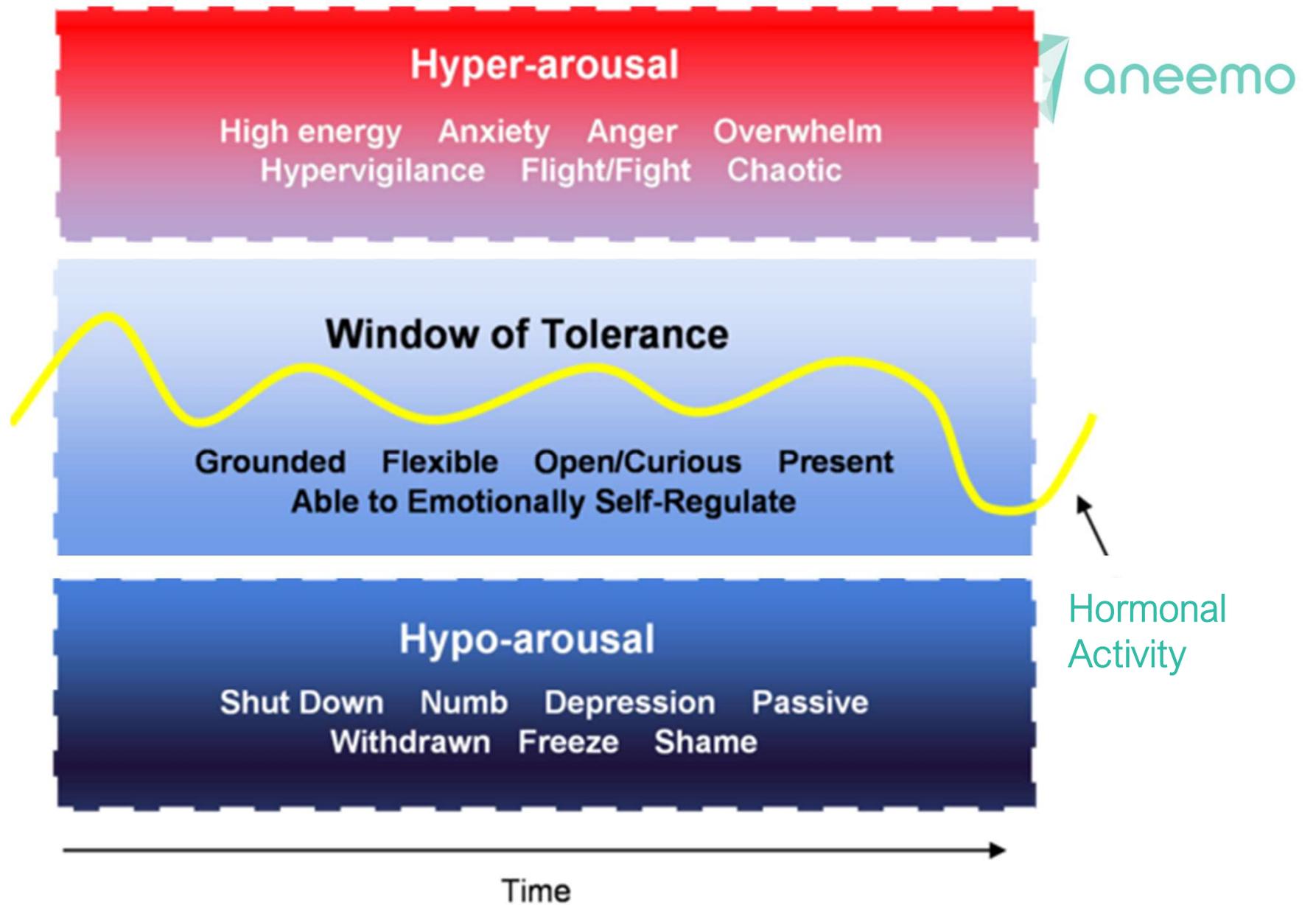
Impact of Trauma

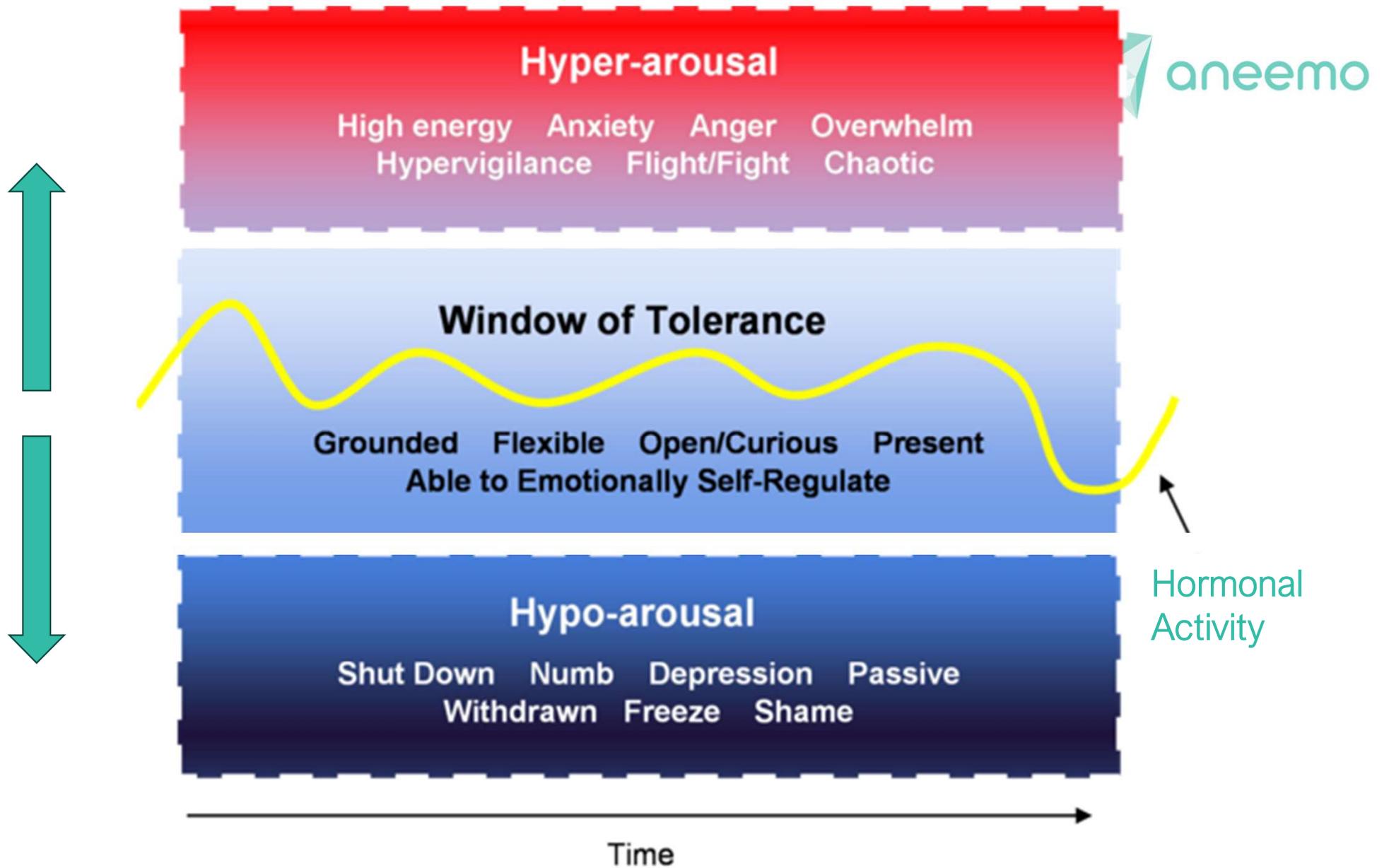
- **Disconnection**
- **Disempowerment**

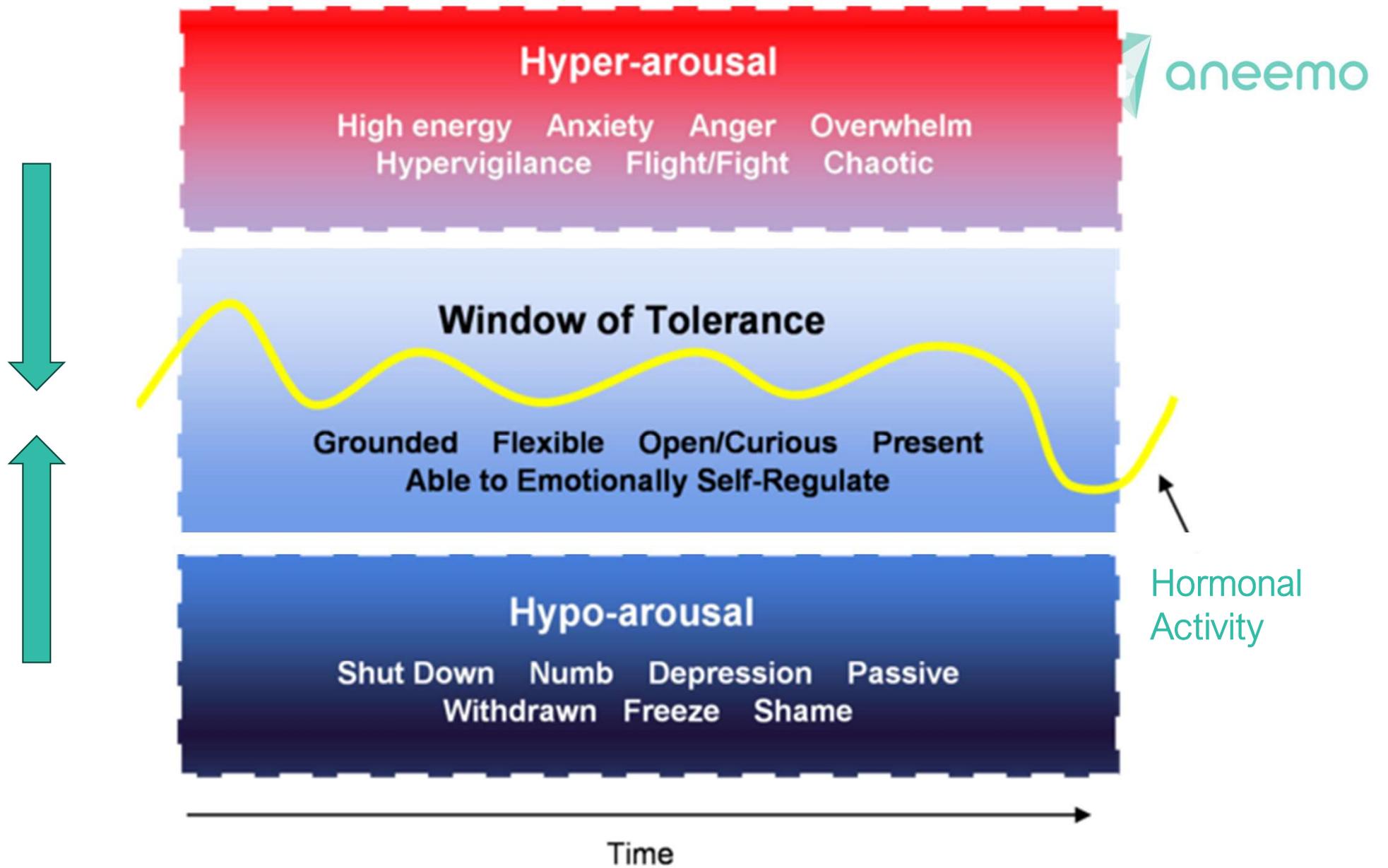
Judith Herman (2017)



Window of Tolerance









How can we support people to stay in their Window of Tolerance?

- ✓ Recognise it as a response to fear and distress.
- ✓ Support the person to feel safe and stay in Window of Tolerance (physically, psychologically, etc...)
- ✓ Use grounding techniques

Fight or flight: Support them to find a gentle way to release some energy. Breathing exercises, slowing down, soothing self-talk.

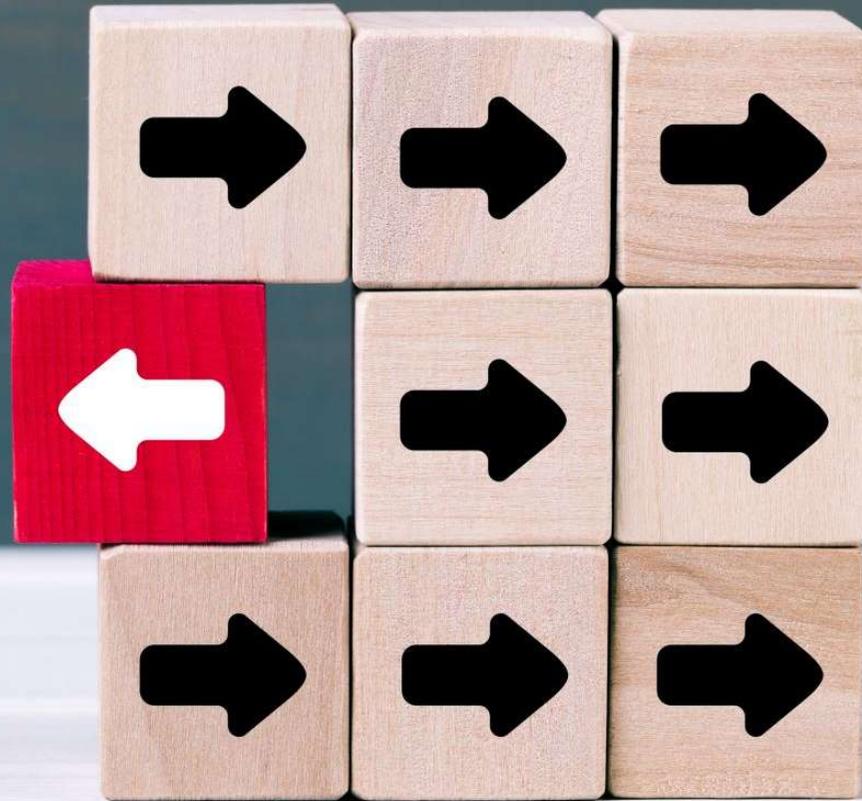
Freeze: Encourage the person to move physically, stand up, change of scene can help. Help person become aware of their current surroundings and tune into their senses e.g 'Can you hear/see the.....'



ALL
behaviour is
communication

Challenging behaviour vs behaviour that challenges?

Why do we use this terminology?



Challenging Behaviour vs Behaviour that Challenges

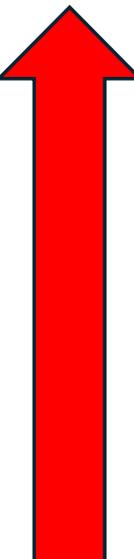
- *Challenging Behaviour* locates the problem within the individual rather than the system
- **It is important to recognise that ‘challenging behaviour’ is the result of an interaction between the person and their environment, and as such is largely socially constructed.**
- The term ‘**behaviour that challenges**’ is preferred as an alternative
- ‘Behaviour that challenges’ refers to it being services, family, carers and the person challenged
 - Behaviour may also serve a function
 - The behaviour may appear only in certain environments
 - Same behaviour may be considered challenging in some settings/contexts, not in others.
 - Staff sometimes disagree about whether a behaviour is challenging,
 - Different experiences, perspectives and cultural differences underlie this
- Some environments increase the likelihood of behaviour that challenges, esp. if:
 - *limited choice and control,*
 - *Limited meaningful, responsive connection with others,*
 - *Physically &/or Psychologically Unsafe*

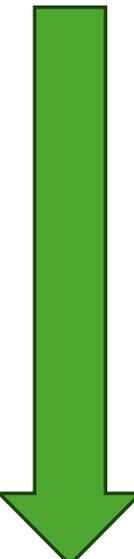
Preventative and De-escalating Responses

How do you deal with someone becoming distressed and agitated?



Responses from us.....

- 
- A large, solid red arrow pointing upwards, positioned to the left of the 'Escalation Responses' list.
- Possible **Escalation** Responses
 - Overly firm or aggressive
 - Losing your patience
 - Being experienced as unhelpful
 - Dismissive
 - Uncaring

- 
- A large, solid green arrow pointing downwards, positioned to the right of the 'De-escalation Responses' list.
- Possible **De-escalation** Responses
 - Calm
 - Listening
 - Taking time
 - Helpful
 - Concerned / Empathic

People will commonly be 'triggered' into an angry or defensive reaction if they feel:

Embarrassed / Shame / Humiliation / Lose face
Insulted / Mocked, belittled or laughed at
Not taken seriously / Ignored or uncared for

3

Boundaries

Many exclusions are **not about “bad behaviour”**, but about **trauma-shaped relationships with boundaries**.

If we change how we **understand and respond to boundaries**, we can reduce exclusions and keep people engaged.



What do we mean by Boundaries?

Definition *“that which keeps something in and other things out”*

- People need boundaries in order to maintain a separate identity.
- From the separateness we can then relate to others as different from us.
- Sometimes people struggle because their early experiences lacked the safe consistent boundaries they needed.
- This can mean they need boundaries from us and are also greater risk of boundary violations.
- **Professional boundaries** are a set of guidelines, expectations and rules which set the ethical standards in health, support and care settings. This includes outlining safe, acceptable and effective behaviour and practice by workers and organisations.

How do “Boundaries” develop?

Why do attachment matters?

- Boundaries = **predictable limits + relational safety**
- Boundaries are learned **in relationships**, not through rules
- Early attachment experiences shape:
 - Trust in authority
 - Tolerance of limits
 - Expectations of rejection or punishment
 - Formation of the sense of self
- Boundaries ≠ control or punishment
- Boundaries = *“I know where I stand, and you’re still here.”*

Boundaries and Trauma

- Many people using day centres learned boundaries in unsafe, inconsistent, or harmful relationships.

Complex trauma affects:

Emotional regulation
Threat perception
Trust in services

Boundaries may feel:

Arbitrary
Dangerous
A precursor to abandonment

Why this matters for exclusion?

- Boundary testing = **information seeking**, not defiance

“Will you still help me if I cross this line?”

- Reframe behaviour as *relational communication*
- Exclusion often confirms the person’s trauma narrative:

“I knew it — services always reject me.”

ATTACHMENT THEORY



SECURE

SELF-ASSURED,
DIRECT, RESPONSIVE



PREOCCUPIED

SELF-DOUBTING,
ANXIOUS, SENSITIVE



DISMISSIVE

SELF-RELIANT,
AVOIDANT, DISTANT



FEARFUL

SELF-SABOTAGING,
UNPREDICTABLE, ISOLATED

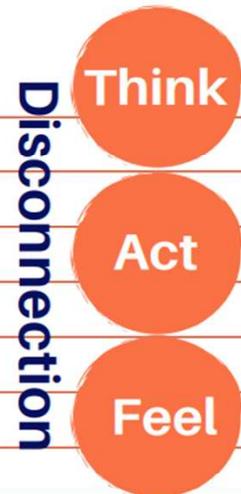
Entanglement

zone of balance

Disconnection

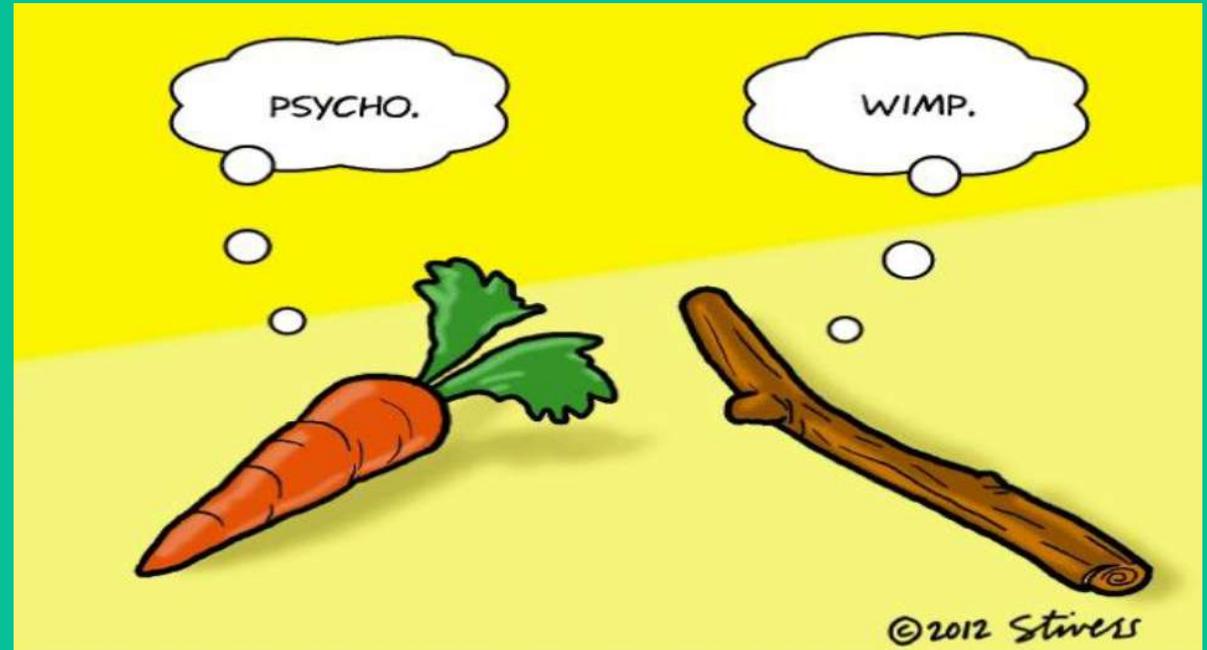


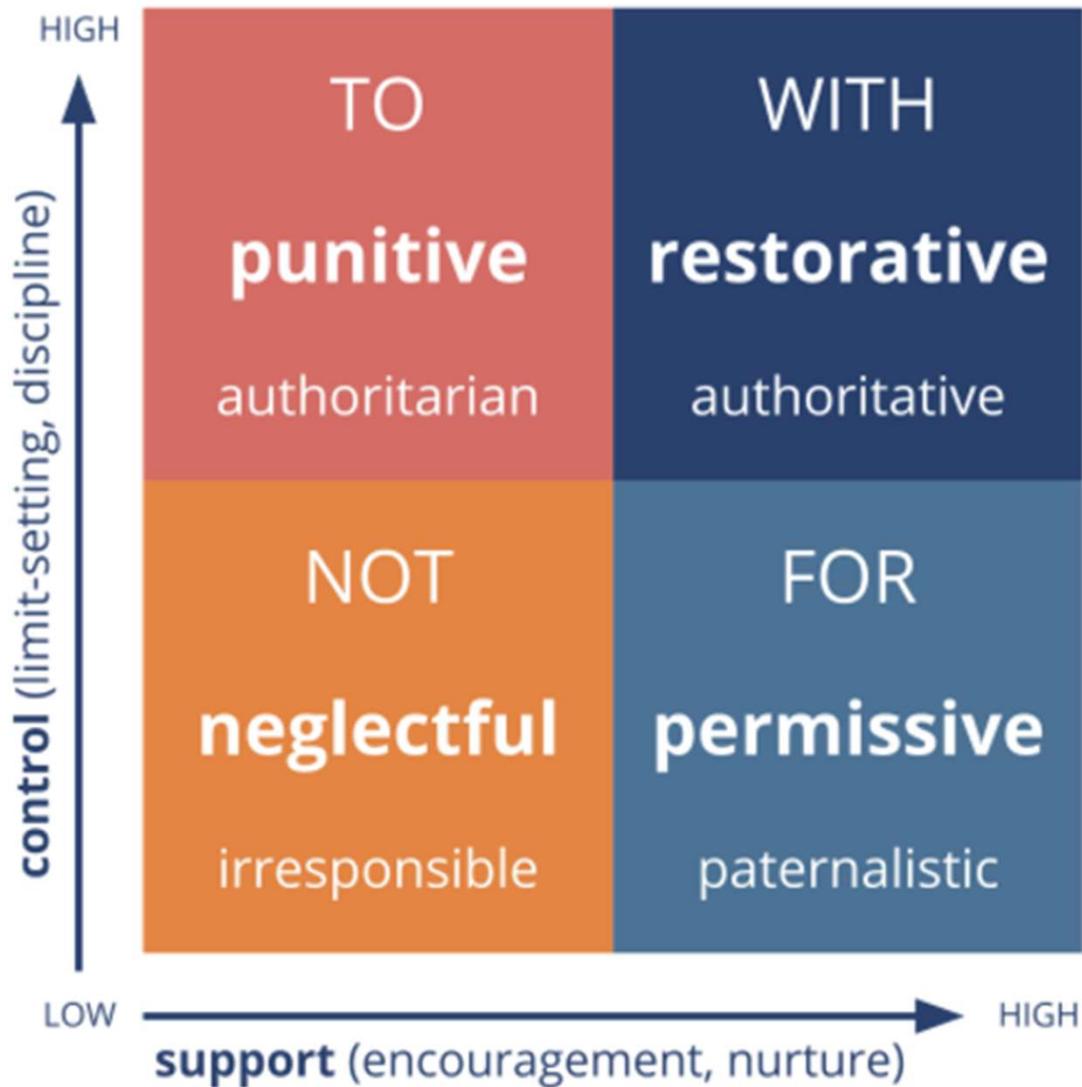
How do you slip out of the zone of balance?



4

What
promotes
Behaviour
Change?



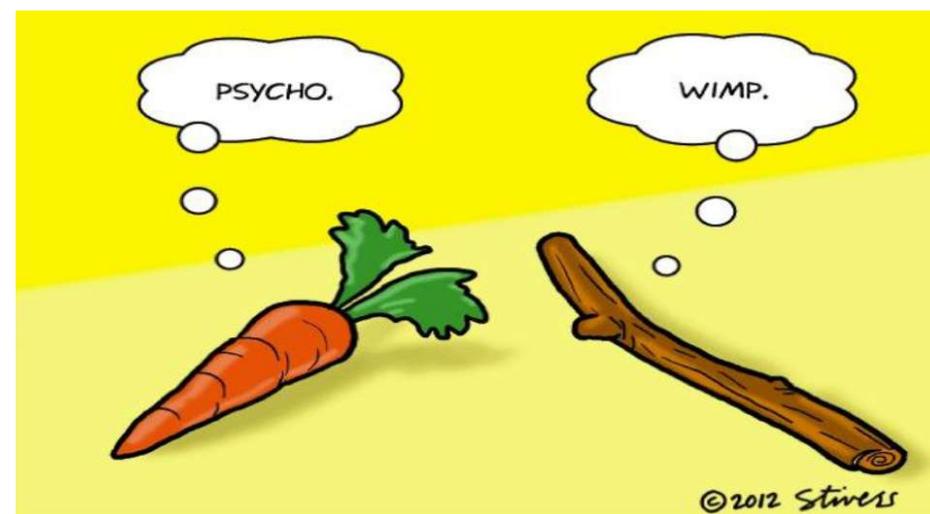


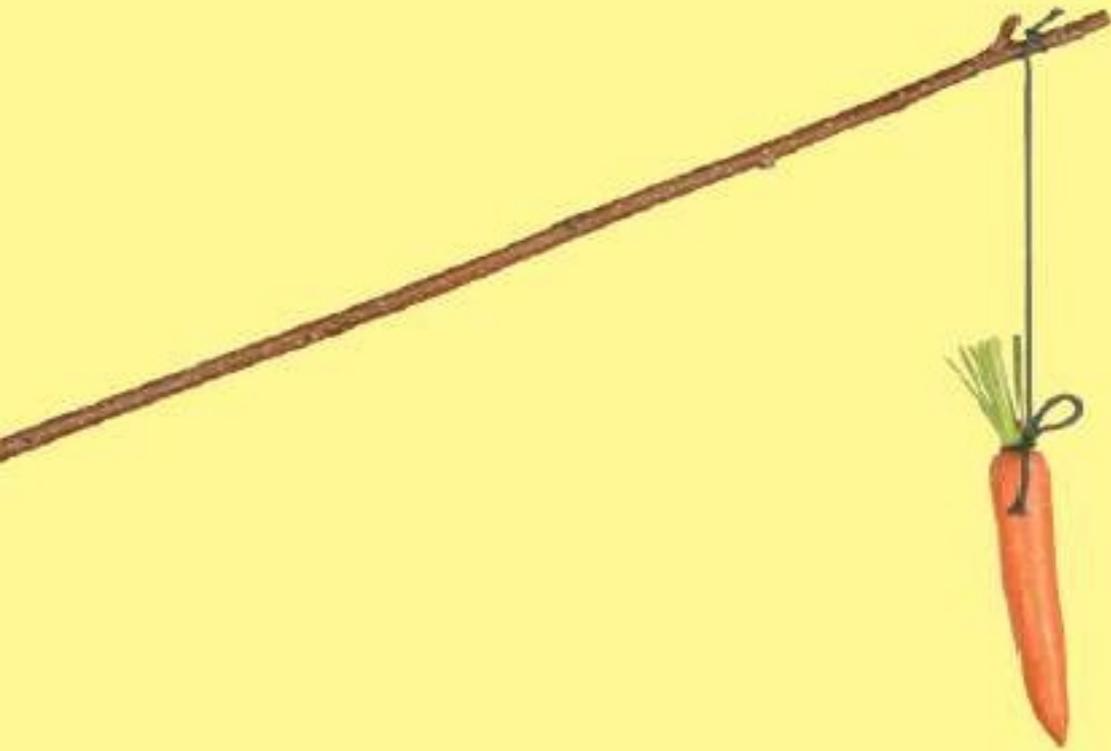
Balancing limit setting
alongside support

Praise and Sanctions



- Be consistent to that behaviour for that individual
- It is important to clearly explain the reasons and suggest alternatives
- **Five to one rule**: Mary Poppins ‘sugar with the medicine’
 - bad interactions are more emotionally powerful and so need a dose response
 - crucial to balance disagreeable interactions with more positive interactions
 - people more likely to take a critique if they have built-up some good will
- More effective to praise alternative behaviours & try to ignore negative
- Respond as close to action as possible
- Praise in public, critique in private





"As we grow, let us realize that motivation lies in neither the carrot nor the stick, but in the simple process of moving forward, which is in itself its own reward."

Rand MacIvor, 2010

Resisting Re-traumatisation



Relational Retraumatization Power & Control	Systemic Retraumatization Policies & Practices
Not seen or heard Violating Trust No collaboration Do things for or to No emotional safety Coercive, punitive,	Continually re-telling story No personalisation Treated as a number/label No choice No feedback opportunities

- Resisting Re-traumatisation: understand operational practices, power differentials,
- Empowerment, choice, control
- Collaboration and mutuality with an understanding of power imbalances
- Trustworthiness and transparency with the aim of building trust

From Theory to Practice (Part 1)



Elastic Tolerance & Behavioural Agreements

Elastic tolerance

- Clear non-negotiables (safety)
- Flexibility elsewhere
- Staff consistency > staff strictness

Behavioural agreements

- Co-created, not imposed
- Focus on:
 - What helps the person stay
 - What support looks like when things go wrong



A photograph showing four hands of different skin tones cupped together, holding a small, glossy pink heart. The background is a soft, light blue gradient.

From Theory to Practice (Part 2)

Reviews, Repair, and Reducing Exclusion

Review after:

- Any significant boundary rupture or incidents
- +
 - At set intervals
 - When things are going well

Why this matters

- Prevents attention only reinforcing negative behaviour
- Creates structured opportunities for praise and repair
 - Builds trust and relationships

Take Home Reflections

- Boundary testing is often **trauma communication**
- Consistency builds safety more than punishment
- Exclusion should be:
 - Rare
 - Thoughtful
 - Actively repaired afterwards

The goal isn't perfect behaviour — it's sustained connection.

Perhaps reflect with your team: *“Which boundaries in our service are about safety — and which might be about anxiety?”*

Support from aneemo

Health and social care training made simple



Positive Behavioural Support: Managing Behaviours that Challenge

Re-formulating 'challenging behaviour' and behaviour change through praise and reward



Boundaries and Disclosure

Managing boundaries and service user disclosure



Solution Focused Approaches to Support Work

Shift the focus from trying to understand problems to supporting the development of solutions.



Working Positively with Risk and Safety

Skills for frontline staff working with those who pose a risk to self and others.



De-escalation Training

Everything you need to know about de-escalation



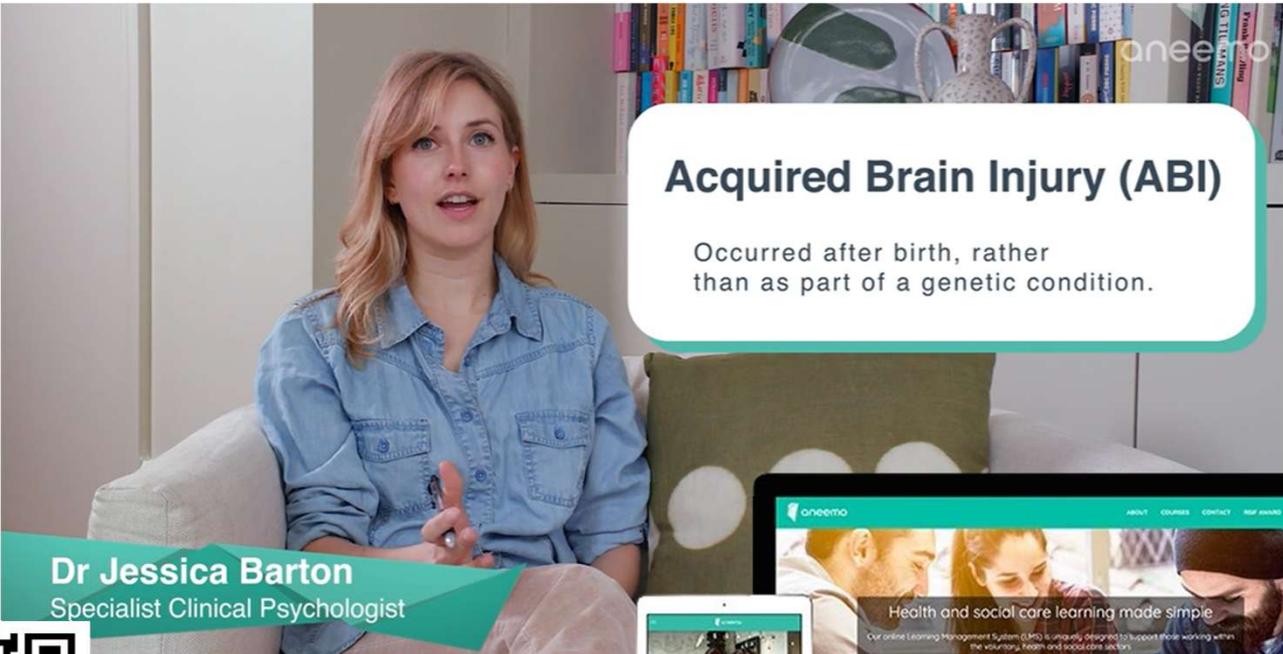
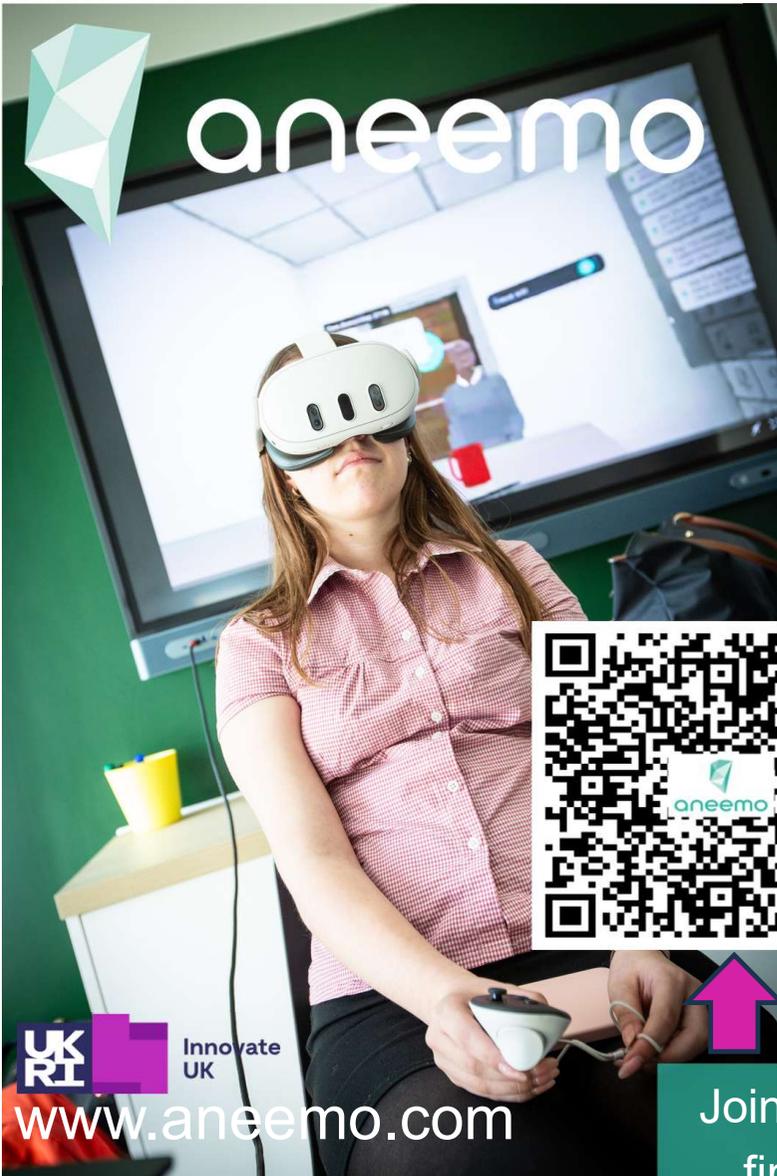
Trauma Informed Leadership

Leading with Empathy and Insight



www.aneemo.com

The only online training platform dedicated to specialist staff training for the homelessness sector.



Dr Jessica Barton
Specialist Clinical Psychologist

Acquired Brain Injury (ABI)
Occurred after birth, rather than as part of a genetic condition.



Join the waiting list here to be the first to know when the course



Empowering frontline workers to
help those in society who need it most



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Thank you

emma@aneemo.com
contact@aneemo.com
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