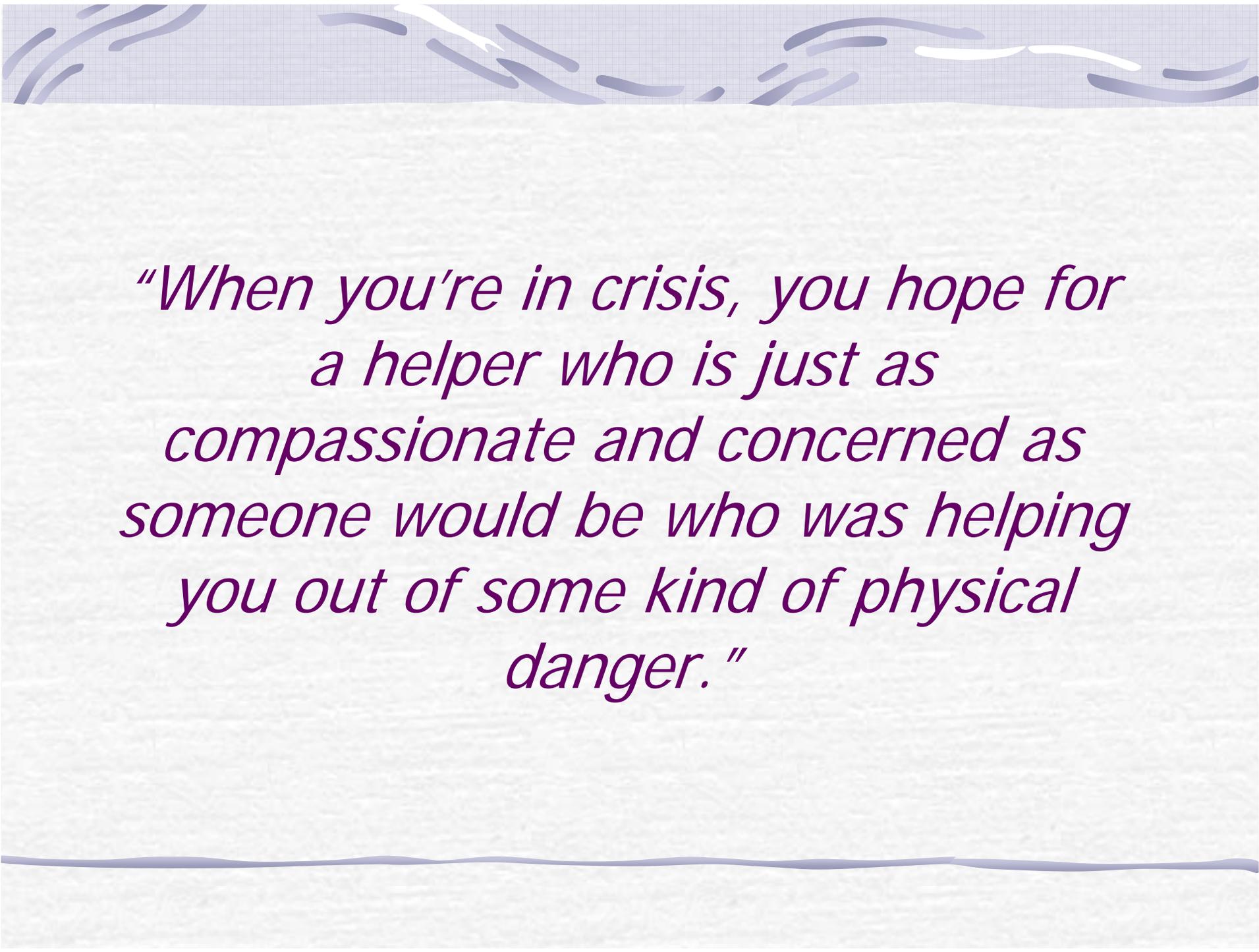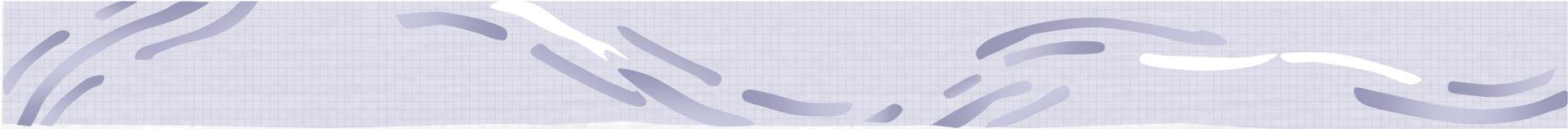# Trauma Informed Care

Trauma Informed & Trauma Sensitive...the only way to do business!

DHS-Oregon State Hospital

Education & Development Department

Pat Davis-Salyer, M.Ed.

"When you're in crisis, you hope for a helper who is just as compassionate and concerned as someone would be who was helping you out of some kind of physical danger."

Goals & Objectives

a) Overview of Trauma Policy and History of TIC

b) Understand the high prevalence of trauma and the impact on treatment and person-centered care

c) Recognize trauma response behavior, triggers, early warning signs, crisis response

d) Listen to the experts – what works is individual

e) Experience the first steps to building a self-care trauma recovery tool box

Today's AGENDA
What to Expect

- Welcome! Introductions (is this always TIC?)
- History of Oregon's trauma sensitive work
- What Helps, What Doesn't
- Triggers and Early Warning Signs
- Voice of Survivors
- Creating safety, building trust
- A look at a trauma self-care tool box

Who's the Policy For?
DHS-AMH 2006 Policy

- All state and community providers, and those who oversee public mental health and addiction services.

- Screen/Assess for the presence of symptoms and problems related to trauma...then what?

- Each agency to develop a trauma policy and offer services that facilitate recovery – ISSR **309-032-1510 (pg. 16-17)**

Trauma Informed	Non-Trauma Informed
Recognition of high prevalence of trauma	Lack of education on trauma prevalence & "universal" precautions
Recognition of primary and co-occurring trauma diagnoses	Over-diagnosis of Schizophrenia & Bipolar D., Conduct D. & singular addictions
Assess for traumatic histories & symptoms	Cursory or no trauma assessment
Recognition of culture and practices that are re-traumatizing	"Tradition of Toughness" valued as best care approach

Trauma Informed	Non-Trauma Informed
Power/control minimized - constant attention to culture	Keys, security uniforms, staff demeanor, tone of voice
Caregivers/supporters – collaboration	Rule enforcers – compliance
Address training needs of staff to improve knowledge & sensitivity	"Patient-blaming" as fallback position without training
Staff understand function of behavior (rage, repetition-compulsion, self-injury)	Behavior seen as intentionally provocative

Trauma Informed	Non-Trauma Informed
Objective, neutral language	Labeling language: manipulative, needy, "attention-seeking"
Transparent systems open to outside parties	Closed system – advocates discouraged

(Fallot & Harris, 2002; Cook et al., 2002, Ford, 2003, Cusack et al., Jennings, 1998, Prescott, 2000)

Definition of Psychological Trauma

- The cluster of symptoms, adaptations, and reactions that interfere with the daily functioning of an individual who has experienced extreme suffering (including neglect and deprivation) secondary to severe physical abuse and injury, sexual abuse, witnessing or surviving severe community or domestic violence...(see AMH Policy handout)

Background

- Long-term adverse effects of interpersonal violence, abuse, neglect, and other serious traumatic experiences are seen in people from infancy to old age, across gender, race, culture, socioeconomic status, intelligence, or education level.

- Don't be fooled…it can happen to anyone!

Trauma can occur at any age.

Trauma can effect any:

- race
- gender
- ethnicity
- socio-economic group
- community
- workforce

Exposure to Trauma

Trauma can occur from:

- Being in a car accident or other serious incident
- Having a significant health concern or hospitalization
- Sudden job loss
- Losing a loved one
- Being in a fire, hurricane, flood, earthquake, or other natural disaster
- Witnessing violence
- Experiencing emotional, physical, or sexual abuse
- Perception or reality of losing one's life!

Types of Trauma

A single traumatic event that is limited in time.

The experience of multiple traumatic events.

Acute Trauma

Chronic Trauma

Vicarious Trauma

Complex Trauma

System Induced Trauma

Both exposure to chronic trauma, and the impact such exposure has on an individual.

The traumatic removal from home, admission to a detention or residential facility or multiple placements within a short time.

Exposure to Trauma

Trauma can be:

- A single event

- A connected series of events

- Chronic lasting stress

Trauma is under-reported and under-diagnosed.

(NTAC, 2004)

Exposure to Trauma

It is an individual's experience of the event, not necessarily the event itself that is traumatizing.

Protective Factors

Protective Factors

- Parental resilience

- Social connections

- Knowledge of parenting and child development

- Concrete support in times of need

- Nurturing and attachment/social and emotional competence of children
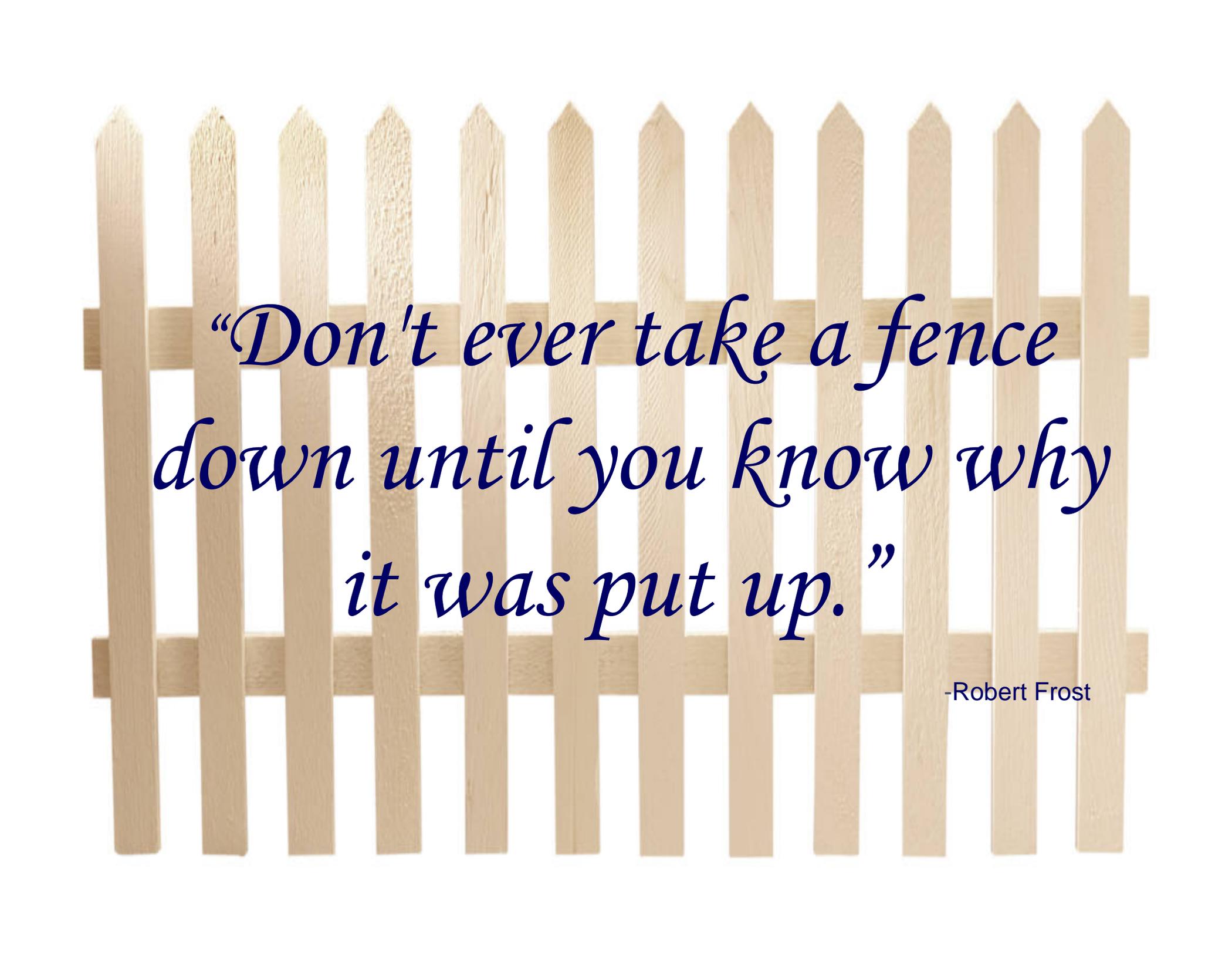
"*Don't ever take a fence down until you know why it was put up.*"

-Robert Frost

Policy put it into Practice!

- Is it underline expensive to implement:
  - Trauma Informed Care?
  - Trauma Sensitive Services?
  - Trauma Awareness?
- Is the training program complicated, or more common sense - RB?
- Are TIC and TSS resources available?

Policy put it into Practice!

- More than concepts – real relationship-based care:
  - Dignity
  - Respect
  - Validation
  - Listening – be present in the moment
  - Early intervention – right support, right time
  - Build **safety and trust** –foundation stones!

Policy put it into Practice!

- Are individuals diagnosed based on presenting symptoms?

- Are individuals diagnosed based on behavior.

- Do these "visible" signs always reveal major underlying issues?

- In your experience, would you say that coping mechanisms, habits, behaviors often cover up trauma histories?

Barriers To A Systemic Understanding Of Trauma And Trauma Informed Care

- Stigma, Social Distance, and Lack Of Familiarity
- Lack of Educational Priorities
- Lack of Trauma Trained Sensitive Staff
- Social conventions that support stigma
- Lack of common experience
- Lack of A Diagnostic Science That Can Adapt To Environmental Determinants
- Administrative Intolerance Of Change
- Lack of Empathy
- Resistance to Change
- Fear and staying in old fall-back patterns of response – self protection (fight or flight)

Definition of Trauma Informed Care

TRAUMA
INFORMED CARE

Providing the foundation for a basic understanding of the psychological, neurological, biological, and social impact that trauma and violence have on many of the individuals we serve.

Incorporates proven practices into <u>current operations</u> to deliver services that acknowledge the role that violence and victimization play in the lives of most of the individuals entering our systems.

(NCTIC)

Don't look where you fall, but where you slipped. ~African Proverb

Definition of Trauma Informed Care

Services that are directed by:

- a thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual and *(gathered gently, respect, may take time)*

- an appreciation for the high prevalence of traumatic experiences in persons who receive mental health and addiction services
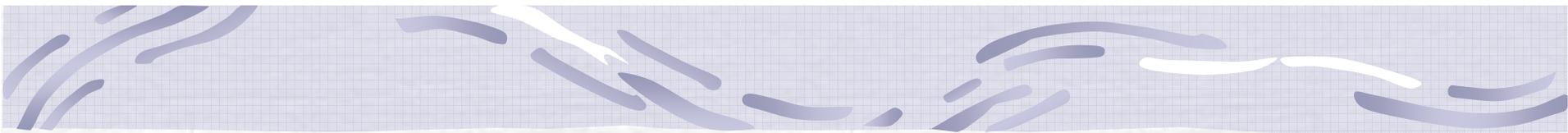
(Jennings, 2004)

Trauma-Informed Care (TIC)

provides a new paradigm under which the basic premise for organizing services is transformed

from:

"What's wrong with you?"

to:

"What has happened to you?"

"It's about the right to have a present and a future that are not completely dominated and dictated by the past."

Karen Saakvitne

Trauma
Informed Care

Services that:

- Promote dignity, respect, trust and safety in our therapeutic, healing environment

- Design treatment, therapeutic relationships, and accommodations to meet patient's needs

- Reflect recovery & person-centered principles

- Reflect patient satisfaction, engagement, and self-empowerment. Patient's in partnership with you!

Trauma
Informed Care

Services that:

- Allow patients time to build trust with staff and safety to share their story about what happened.

- Are dependable, predictable, and creative with **permission** of patient.

- Keep agreements.

- Do no harm. Know each patient, respect their fears and be trustworthy.
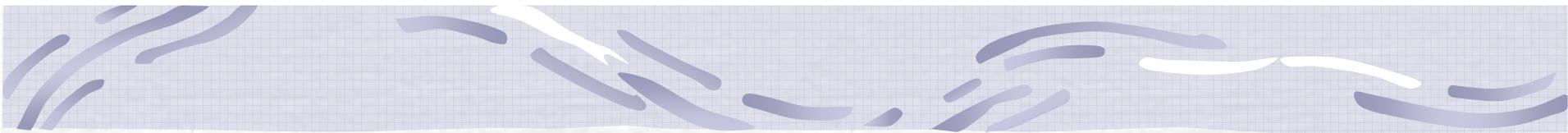
What is a Trauma Informed System?

The commitment of a "trauma-informed" system is to provide all services in a manner that is welcoming and appropriate to the special needs of trauma survivors.

(Refer to Sandra Bloom, Maxine Harris, Roger Fallot's work on system transformation.)

What Are Trauma Specific Services?

Examples of 'clinically' trauma specific services include grounding techniques which help trauma survivors manage dissociative symptoms, desensitization therapies which help to render painful images more tolerable, and certain behavioral therapies which teach skills for the modulation of powerful emotions.

Mind/Body healing, cellular memory, EMDR, Yoga & CBT...what works for you?

(Refer to AMH Trauma Policy, Ann Jennings' definition.)

What Are Trauma Sensitive Services?

Examples of 'peer' trauma sensitive services include care and <u>connection</u> with persons who have lived experience, who are less likely to see the person as a diagnostic criteria and more likely like a victim of a terrible tragedy. Emphasis is often on establishing <u>safety</u> and allowing the person to address their issues in a safe way within their own comfort and on their <u>own timetable</u>.

What Would the Shift Look Like?

- A paradigm shift in assessment, diagnosis, and treatment that <u>identifies trauma as the core event</u>
  - Wider use of trauma-related diagnoses
  - Identification of <u>trauma-related skill deficits</u>
    - **Self-awareness, self-soothing, accurate diagnosing**
  - Treatment to address trauma and the related skill deficits specifically
  - Appreciation of the impact trauma dynamics have on all relationships
    - Betrayal, power, blame, lack of trust, lack of safety

Trauma

Informed Care – In the Moment!

Environment Check Exercise

Look at the room. How would you rate this classroom on a trauma sensitive checklist?

*Access, doorways, how many exits

*Lighting, smells, personal space

*Personal information available? (sign-in)

*Seating arrangement – crowded? Too close?

*Power differential, are your needs met?

*Is this a calming environment, if not, what would help?

Describe A Safe Place for You

Imagine a Time When You Received Safe Help:

- What did it feel like?
- Who helped?
- What helped?
- Was trust a big part of your sense of safety?

Describe A Safe Place for You

Read from "Healing in Safety Handbook"
(page 1 and 2)

If YOU WISH…open the bags in front of you and digest what is presented.

How do we know when learning something moves from head knowledge into system application…or, comes through you?

Types of Trauma

- Neglect and deprivation
- Physical abuse and injury
- Sexual abuse and/or exploitation
- Witnessing or surviving severe community or domestic violence
- Accidents, natural, or human-caused disasters
- Even what was intended to be intervention!
- Inadvertent retraumatization via helpers.

(discussion)

Trauma Is A <u>Primary</u> Condition
"Preponderance of Evidence"

Prevalence rates for trauma such as the following are significant:

100% of those on death row in Florida State Penn are trauma victims, 85% are under age 18!

97% of homeless mentally ill women (Goodman, Johnson, Dutton & Harris, 1997).

This clearly is not a "special population" separate from the majority of clients presently served.

Reported Prevalence of Trauma
Mental Health Population

- **90%** of public mental health clients have been exposed *(Mueser et al., 2004; Mueser et al., 1998)*

- **Most** have multiple experiences of trauma

  (Ibid)

- **34-53%** report childhood sexual or physical abuse *(Kessler et al., 1995; MHA NY & NYOMH, 1995)*

- **43-81%** report some type of victimization

  (Ibid)

Reported Prevalence of Trauma
Mental Health Population

- 97% of homeless women with SMI have experienced severe physical and sexual abuse - 87% experience this abuse both as child and adult
(*Goodman et al., 1997*)

- Current rates of PTSD in people with SMI range from 29-43%

  (*CMHS/HRANE, 1995; Jennings & Ralph, 1997*)

- Epidemic among populations in public mental health and addiction service systems   (*Ibid*)

Reported Prevalence of Trauma

- A majority of adult and children in inpatient psychiatric treatment settings have trauma histories

  (Cusack et al.; Mueser et al., 1998; Lipschitz et. Al, 1999, NASMHPD, 1998)

  "Many providers may assume that abuse experiences are additional problems for the person, rather than the central problem..."

  (Hodas, 2004)
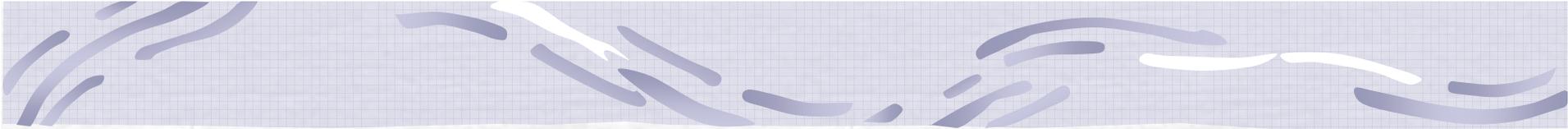
Universal Precaution as a Core Trauma Informed Concept

Presume that every person in a treatment setting has been exposed to abuse, violence, neglect or other traumatic experiences.

Do Survivors Seek Services for Trauma Induced Problems?

- Symptoms/adaptations to trauma are sometimes <u>not</u> recognized by consumer, family, or clinician.

- PTSD and trauma related disorders are often *diagnosed* as:
  - Mood disorders
  - Anxiety & depression
  - Substance use disorders

Do Survivors Seek Services for Trauma Induced Problems?

- What coping tools might a person use dealing with an unresolved trauma history?
- List positive and negative coping mechanisms...
- A personal tool box for self-soothing

Empathy or Lack of It

- The social *acceptability* of the lack of empathy for the clients/victims, or lack of *awareness* of trauma histories

- If you don't know, you don't know…if you don't get it you don't get it. Social norms before paradigm shifts. Walk in my shoes.

This is <u>not</u> most people's idea of 'help'
or 'a supportive person to talk to...'

How Does Practice Compare To Trauma Informed Principles?

- Is empathy present? Do we debrief with staff/clients?

- Is safety possible if the practice defines the clients as incurable, rejects them, or does not recognize trauma?

- Can trauma informed care exist in a system using varying forms of coercion? How to build trust again!

- Can systems that do <u>not</u> accommodate the individual respond to the vast number of circumstances that cause trauma and symptomatic behavior?
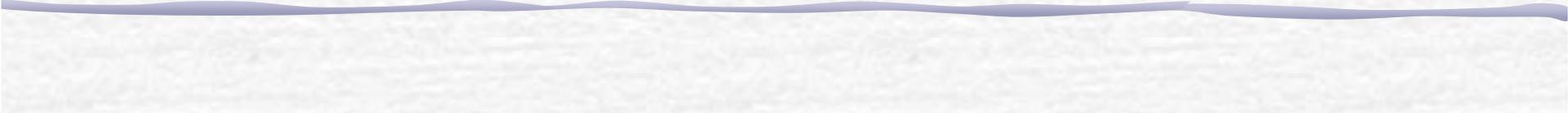
Borderline Personality Disorder [as DSM-IV Defined]

"The essential feature of Borderline Personality Disorder is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts."
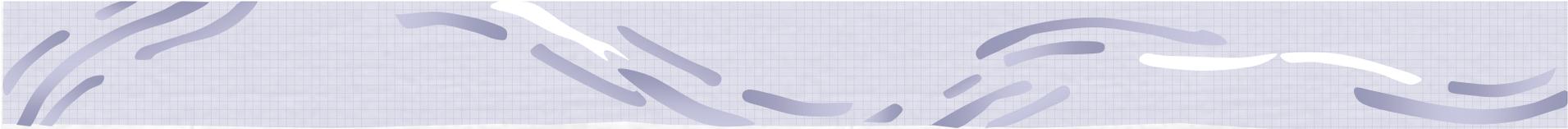
Borderline Personality Disorder

Beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following…

Borderline Personality Disorder

1. Frantic avoidance of real or imagined abandonment.

2. Unstable interpersonal relationships characterized by extremes of idealization and devaluation.

3. Identity disturbed unstable self-image / sense of self.

4. Impulsivity in at least two areas that are self-damaging (e.g. sex, substance abuse)

5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

Borderline Personality Disorder

6. Affective instability due to a marked reactivity of mood (e.g. dysphoria, irritability, or anxiety).

7. Chronic feelings of emptiness

8. Inappropriate, intense anger or difficulty controlling anger

9. Transient, stress-related paranoid ideation or severe dissociative symptoms

Now go back through asking with each symptom.... Could this be the result of trauma? Could this be an adaptive behavior to cope with a traumatic memory, occurrence, or to assist in avoidance?

Staff Behaviors & BPD

When I was a social worker I would roll my eyes when someone mentioned BPD. Why? Because that is what all of my co-workers did. I was educated by my co-workers of how horrible borderlines were. Did I have my own experience with them? Nope. Did they? Nope. But if you rolled your eyes you were showing others that you were well educated about this population. You knew enough about this disorder to know that the borderlines were horrible people and hard to manage. When in real life, I knew nothing of this disorder.

- Pat Fleenor, MSW

Essential Components of TIC – watch for:

1. Triggers

2. Early Warning Signs

3. Coping Strategies

Could we have avoided this cycle???
What did you observe days before?

First, know the person, then identify <u>triggers</u> <u>with</u> <u>the person</u>.

Experiencing Emotional Triggers

"I hated it. You people need to do better...You know me better than that. I hate the restraint bed. It makes me think of my past. How some things happened to my mom. You people do not understand that talking about your past can be very hard to do. I am sorry if I hurt any staff but you all know me. I do not mean to hurt you."

Experiencing Emotional Triggers

Gail Ward, age 17

(LeBel, J., Stromberg, N., (2004) Experiences of S/R. Unpublished Papers)

TRIGGERS

For trauma survivors, it is different…

Triggers

Seeing, feeling, hearing, smelling something that reminds us of past trauma

Activates the alarm system…

PANIC

The response is as if there is <u>current danger.</u>

Thinking <u>brain automatically shuts off</u> in the face of triggers.
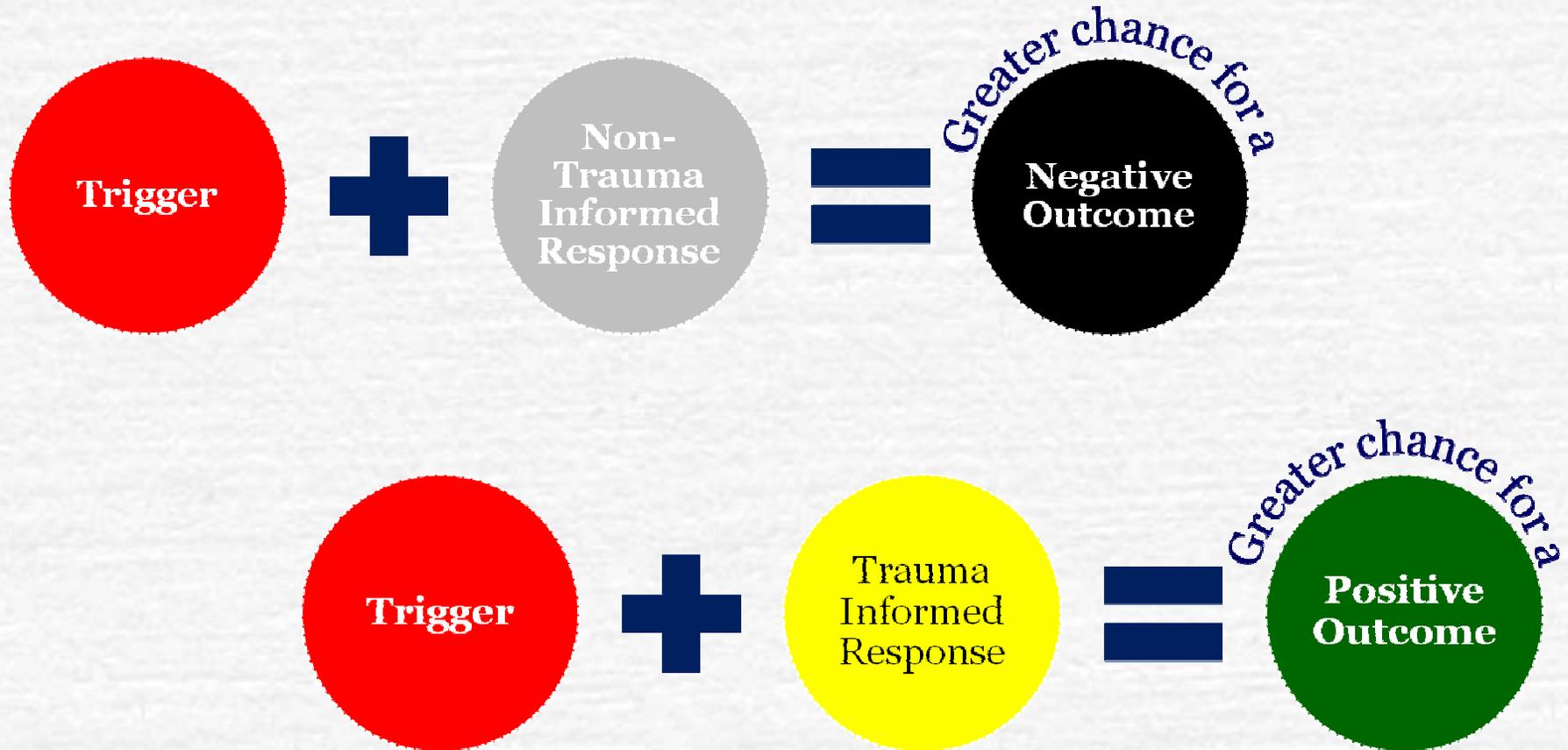
<u>Past and present danger become confused</u>.

Our experience.

A trauma survivor's experience.

Your response is key-

Trigger + Non-Trauma Informed Response = **Negative Outcome** *Greater chance for a*

Trigger + Trauma Informed Response = **Positive Outcome** *Greater chance for a*

Some OSH Triggers

A trigger is something that sets off an action, process, or series of events (such as fear, panic, upset, agitation) a mind/body reaction:

- bedtime
- food
- room checks
- large men
- yelling
- people too close

More Triggers: What makes you feel scared or upset or angry and could cause you to go into crisis?

- Not being listened to
- Lack of privacy
- Feeling lonely
- Darkness
- Being teased or picked on
- Feeling pressured
- Crowds
- Breaking a promise

- Arguments
- Being isolated
- Being touched
- Loud noises
- Not having control
- Being stared at
- Other (describe)

More Triggers:
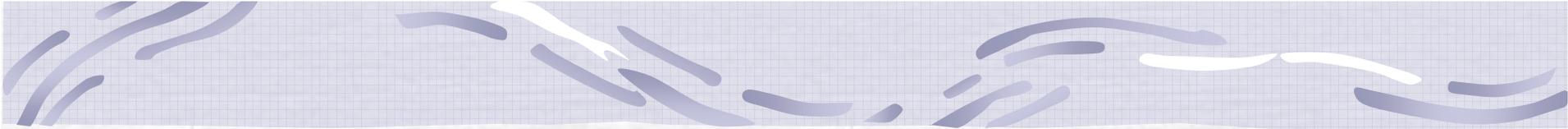
- Particular time of day/night

- Particular time of year

- Contact with family

- Other*

  * We all have unique histories with uniquely specific triggers - essential to ask & incorporate in Treatment Plans

We all have buttons that can be pushed…

Second, Identify <u>Early Warning Signs</u>

Is there a personal plan which lets you know what helps?

Early Warning Signs

A signal of distress is a physical precursor and manifestation of upset or possible crisis. Some signals are not observable, but some are, such as:

- restlessness
- agitation
- pacing
- shortness of breath
- sensation of a tightness in the chest
- sweating
- Know a person well enough to recognize these changes!

Early Warning Signs
What might you or others notice or what <u>you</u> might feel just before losing control?

- Clenching teeth
- Wringing hands
- Bouncing legs
- Shaking
- Crying
- Giggling
- Heart Pounding
- Singing inappropriately
- Pacing

- Eating more
- Breathing hard
- Shortness of breath
- Clenching fists
- Loud voice
- Rocking
- Can't sit still
- Swearing
- Restlessness

Trauma History Behaviors

- Some behavior signals:
  - Changing behavior, mood swings
  - Impulsivity, rapid pacing, fearful
  - Difficulty maintaining attention
  - Self harm, isolation, avoiding
  - Lack of engagement, interest, depression
 - Lack of response to medication
  - Time to evaluate for trauma!
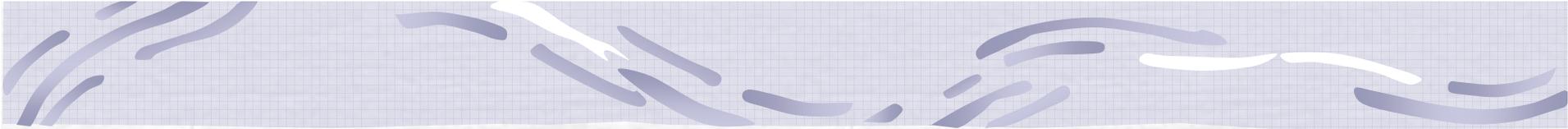
Other signs & symptoms

- Arousal of emotions
- Dissociation
- Suicidal thoughts
- Guilt
- Low self esteem
- Mistrust of others
- Substance abuse, misuse, relapse

Build a Tool Box of Support

Such as a WRAP or a Crisis Prevention Plan Fundamentally it is an *individualized* plan developed in advance to prevent a crisis and avoid the use of secure observation or disciplinary confinement. *(Institution)*
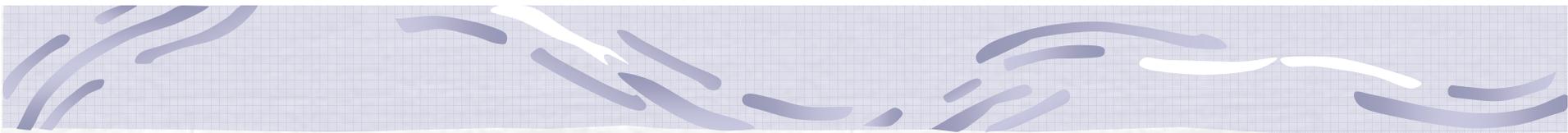
It is:

- A therapeutic process (Trust & Relationship)
- A plan that is trauma sensitive
- A plan that is tailored to the needs of each individual – how are they used at OSH?
- A **partnership** of safety planning
- A **collaboration** between *a patient* and staff to create a crisis strategy together
- Remember age appropriate! (consider 17-24 y.o.)

Why are safety tool kits used?

Purpose:

- To help individuals during the earliest stages of escalation way before a crisis erupts

- To help individuals identify coping strategies before they are needed

- To help staff plan ahead and know what to do FOR each person if a problem arises

- To help staff use interventions that reduce risk and trauma to individuals (everyone involved!)

So, what is Trauma Informed?
NOT a mystery!

A trauma-informed system is one in which all components of a given service system have been <u>reconsidered</u> and evaluated in **light of a basic understanding of the role that trauma plays in the lives of people seeking services.**

- Respect, dignity, accommodation, rapport

- Services that avoid inadvertent re-traumatization and will **facilitate a person's participation in treatment**.
- A collaborative relationship with other public sector service systems and private practitioners with trauma-related clinical experience build a network of support.
- Ask "what happened?" Listen! Respect!

Though no one can go back and make a brand new start, anyone can start from now and make a brand new ending.

Carl Bard
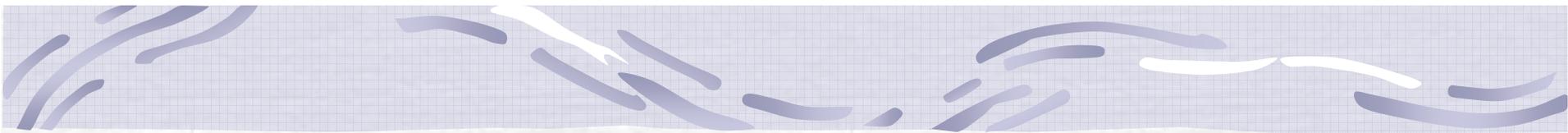
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