
Introduction to Trauma-Informed Care
…when the past is always present
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Lewis & Clark College
Northwest Institute of
Addictions Studies
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Introduction to Trauma-Informed Care
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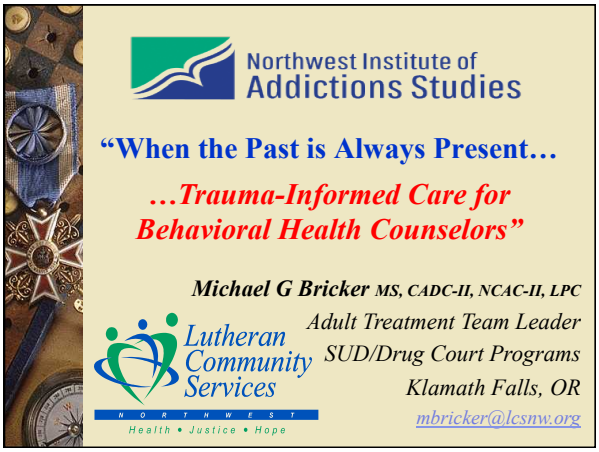
Northwest Institute of
Addictions Studies
"When the Past is Always Present…
…Trauma-Informed Care for Behavioral Health Counselors"
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Health • Justice • Hope

## What are YOUR personal learning goals for today?

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## DSM-5 Criteria for PTSD

***(A) Exposure to actual or threatened death, serious injury or sexual violence:***

- Directly experiencing the trauma;
- Personally witnessing trauma occurring to others;
- Learning of accidental trauma to close family or friends;
- Extreme or repeated exposure to the effects or aftermath of trauma (eg. EMTs, Police)

## (B) One or more intrusive symptoms associated with traumatic event:

- Recurrent, involuntary intrusive recall;
- Recurrent nightmares related to event;
- Dissociative reactions ("flashbacks");
- Intense or prolonged psycjological distress upon exposure to internal or external cues;
- Marked physiological reactions to internal or external reminders

## (C) Persistent avoidance of reminders *(1 or both)*

- Avoidance or attempts to avoid distressing memories, thoughts or feelings about or associated with the event(s);
- Avoidance or efforts to avoid external reminders (eg. people, places, activities, objects, situations that arouse such memories, thoughts or feelings;

## (D) 2+ associated negative changes in cognition and mood

- Amnesia for the event(s)
- Persistent and exaggerated beliefs or ex-pectations about self, others or the world;
- Persistent distorted cognitions about the causes or consequences;
- Persistent negative emotional state
- Markedly diminished interest or participation in significant activities;
- Feelings of detachment or estrangement;
- Persistent inability to experience positive emotions (anhedonia)

## (E) Marked change in arousal and reactivity *(2 or more)*

- Irritability and anger outbursts;
- Reckless, self-destructive behavior;
- Hypervigilance;
- Exaggerated staratle response;
- Problems with concentration;
- Sleep disturbance (DFA or restless)

## Possible specifiers:

- Depersonalization: persistent or recurrent experiences of feeling detached or outside one's self (eg. as in a dream, observing self from outside, time distortion)
- Derealization: feeling as though current surroundings are unreal, dreamlike or distorted
- With Delayed onset (> 6 months post)
- (Separate criteria for children < 6 y/o)

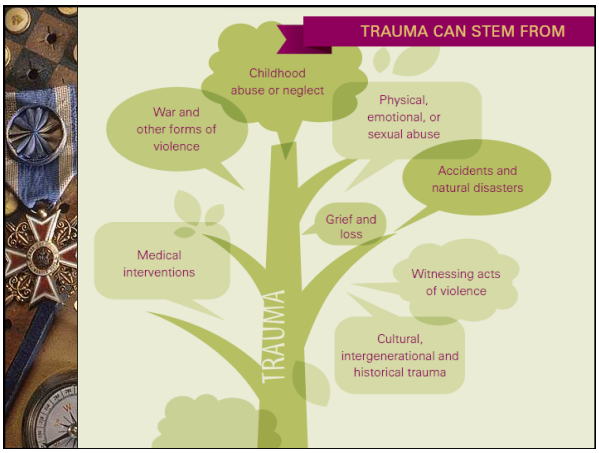
## Working definitions

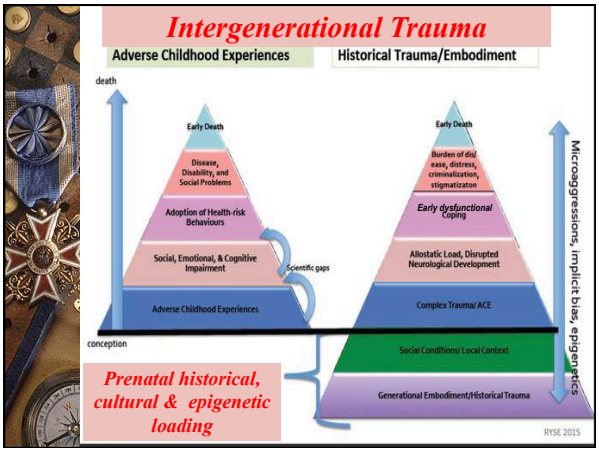
- "Classic" PTSD
  - Single episode trauma – *eg. auto accident or medical emergency*
  - Multiple trauma exposure - *eg. military, EMTs*
- "Complex" PTSD (Courtis & Ford 2009)
  - Repetitive or prolonged trauma exposure
  - Direct harm, neglect or abandonment by caregivers or responsible adults
  - Occurring at developmentally vulnerable times
  - Potential to severely compromise normal development

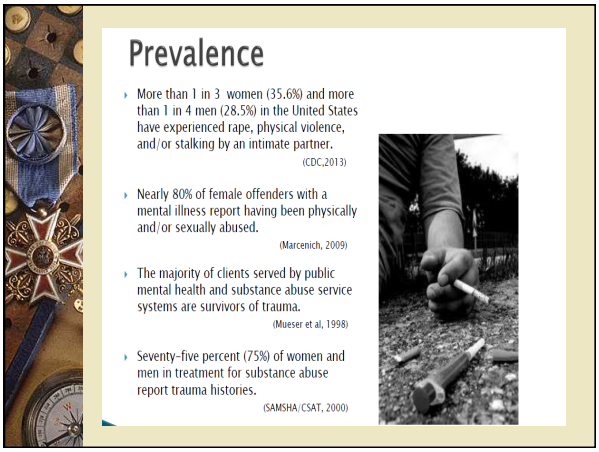
## Mnemonic for PTSD

| DREAMS | |
|---|---|
| D | Detachment (generally numb emotional responsiveness) |
| R | Reexperiencing the event (nightmares or flashbacks) |
| E | Emotional effects (emotional distress, helplessness, fear) |
| A | Avoidance (avoiding things that are reminders of the event) |
| M | Months of duration |
| S | Sympathetic hyperactivity and hypervigilance (insomnia, irritability, difficulty concentrating) |

Acronym adapted from Lange J, Lange C, Cabaltica R: Primary care treatment of post traumatic stress disorder. *Am Fam Physician* 2000; 1035-1040.


TRAUMA CAN STEM FROM
Childhood abuse or neglect
Physical, emotional, or sexual abuse
War and other forms of violence
Accidents and natural disasters
Grief and loss
Medical interventions
Witnessing acts of violence
Cultural, intergenerational and historical trauma
TRAUMA


Intergenerational Trauma
Adverse Childhood Experiences
Historical Trauma/Embodiment
death
Early Death
Disease, Disability, and Social Problems
Adoption of Health-risk Behaviours
Social, Emotional, & Cognitive Impairment
Adverse Childhood Experiences
Scientific gaps
conception
Early Death
Burden of dis/ease, distress, criminalization, stigmatizaton
Early dysfunctional Coping
Allostatic Load, Disrupted Neurological Development
Complex Trauma/ ACE
Social Conditions/ Local Context
Generational Embodiment/Historical Trauma
Microaggressions, implicit bias, epigenetics
Prenatal historical, cultural & epigenetic loading
RYSE 2015


Prevalence
More than 1 in 3 women (35.6%) and more than 1 in 4 men (28.5%) in the United States have experienced rape, physical violence, and/or stalking by an intimate partner.
(CDC,2013)
Nearly 80% of female offenders with a mental illness report having been physically and/or sexually abused.
(Marcenich, 2009)
The majority of clients served by public mental health and substance abuse service systems are survivors of trauma.
(Mueser et al, 1998)
Seventy-five percent (75%) of women and men in treatment for substance abuse report trauma histories.
(SAMSHA/CSAT, 2000)

## Trauma Informed Care

- Aims to avoid re-victimization.
- Appreciates many problem behaviors began as understandable attempts to cope.
- Strives to maximize choices for the survivor and control over the healing process.
- Seeks to be culturally competent
- Understands each survivor in the context of life experiences and cultural background.

(Alvarez and Sloan, 2010)

## Trauma-Informed Care

- **What** ***is "trauma-informed care"***
- **Who** ***needs it?*** **Who** ***should do it?***
- **How** ***do we go about it?***
- **Where** ***should we be doing it?***
- **When** ***should we start?***

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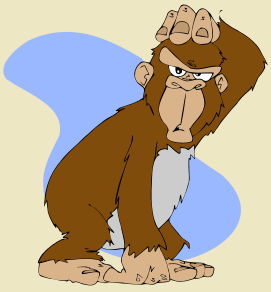
## Soooo…
## why don't we?



## Working with "persons who come from the experience of trauma":

- Huh? Who are they?
  - They are not "victims"
  - They are not "survivors"
  - Labels keep them "trapped in their story"
  - They are people who have had a unique opportunity to develop a set of strengths and resiliency that we need to understand…
  - …and that they need to feel ***safe*** enough to share with us!

## Working with "persons who come from the experience of trauma":

- Starts *before* they walk in the door
  - What is your Agency's reputation in the consumer community? *(Do you know?)*
- Requires us to become aware of THEIR awareness
  - Is the waiting room calm and welcoming?
  - Are the support staff friendly and helpful?
  - What are some perceptual barriers we may not have thought about?

## Working with "persons who come from the experience of trauma":

- How are *potential* clients greeted?
  - Just because they're here doesn't mean they're engaged
  - They're "sizing you up" before you're even aware of it! *(How did you dismiss the client before them?)*
  - A welcoming smile turns a handshake into a "heart-shake"

## Working with "persons who come from the experience of trauma":

- We're always asking them to examine their values and assumptions…
- …have we examined OURS?
  - What are "they" like?
  - Why do you think they are here?
  - Transference and countertransference
  - When you're stressed – and you will be! – where do you fall on the Karpmann Triangle?

## Working with "a person who comes from the experience of trauma":

- Requires a different "heart-set" as well as mindset
  - "You never get a second chance to make a first impression"
  - "they may forget what you said or did – but not how you made them feel"
  - Requires a level of openness to their experience that challenges our traditional boundaries

## Working with "a person who comes from the experience of trauma":

- Counseling 101
  - "They don't care what you know until they know that you care"
  - "If your only tool is a hammer, you'll treat every client like a nail" - Carl Rogers
  - Whose needs are getting met here? Why did ***they*** come here, and how am I helping them toward that goal?
  - "I don't care why they came – I only care about why they stay"

## Working with "a person who comes from the experience of trauma":

- Bear in mind that RULES are not safe!
  - "Rules" are what other people in power used to hurt me
  - "Rules" only seem to work for the other guy
  - Developmentally, many clients are at a maturity level where "rules" are only meant to be challenged, evaded or manipulated
- Trust and transparency rely on ***reasons***, not just rules. *("What's the WHY?")*

## For instance - "Group Rules" are usually a waste of time…

- They're based on the "establishment" expectations for minimally acceptable behavior…
- …the "lowest common denominator" of compliance
- They are based on a power differential…
- …which often leads to a power struggle!
- They tell the group exactly how to challenge your control.

***…and they won't disappoint you!***

## "Group Norms" may be more effective:

- They are the Group's expectations of each other
- They tend to hold members to a higher standard of participation
- They are usually self-reinforcing by way of peer feedback
- They let the Group struggle with itself, instead of with you
- But of course… ***YOU shape the norms by your behavior!***

## But we gotta have rules, right?

So Keep it simple: "Just for today I commit to

**H** *onesty with myself and others*

**O** *penness to others' beliefs and opinions*

**N** *ot "preach" or attack my peers*

**O** *ffer my truth quietly and respectfully*

**R** *espect the privacy of the Group"*

## Circle of Care in TIC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## "Everyone has a right to have a future that is not dictated by the past."

Karen Saakvitne

Lewis & Clark College
Northwest Institute of Addictions Studies

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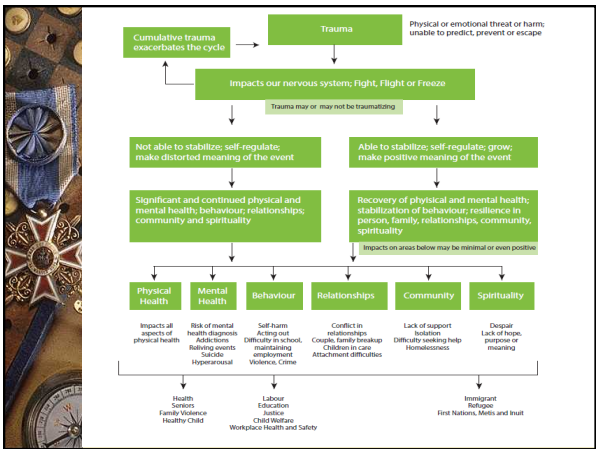
Cumulative trauma exacerbates the cycle
Trauma
Physical or emotional threat or harm; unable to predict, prevent or escape
Impacts our nervous system; Fight, Flight or Freeze
Trauma may or may not be traumatizing
Not able to stabilize; self-regulate; make distorted meaning of the event
Able to stabilize; self-regulate; grow; make positive meaning of the event
Significant and continued physical and mental health; behaviour; relationships; community and spirituality
Recovery of physical and mental health; stabilization of behaviour; resilience in person, family, relationships, community, spirituality
Impacts on areas below may be minimal or even positive
Physical Health
Mental Health
Behaviour
Relationships
Community
Spirituality
Impacts all aspects of physical health
Risk of mental health diagnosis
Addictions
Reliving events
Suicide
Hyperarousal
Self-harm
Acting out
Difficulty in school, maintaining employment
Violence, Crime
Conflict in relationships
Couple, family breakup
Children in care
Attachment difficulties
Lack of support
Isolation
Difficulty seeking help
Homelessness
Despair
Lack of hope, purpose or meaning
Health
Seniors
Family Violence
Healthy Child
Labour
Education
Justice
Child Welfare
Workplace Health and Safety
Immigrant
Refugee
First Nations, Metis and Inuit


Core components of TIC
Acknowledgement of the pervasiveness of traumatic experiences
Safety – for both participants and providers
Atmosphere of Trust
Choice and Control of appropriate elements
Compassionate Collaboration
Strengths-based
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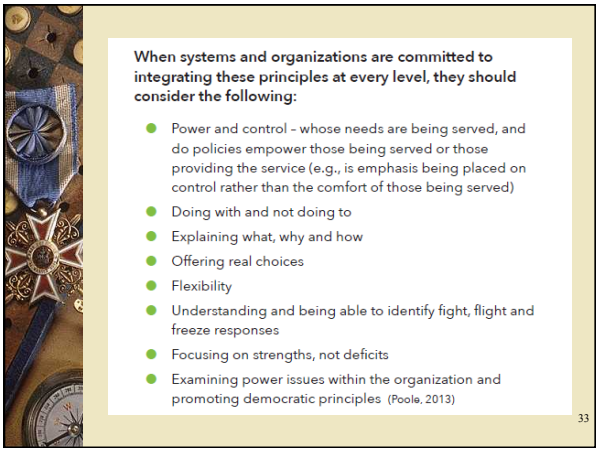
When systems and organizations are committed to integrating these principles at every level, they should consider the following:
Power and control - whose needs are being served, and do policies empower those being served or those providing the service (e.g., is emphasis being placed on control rather than the comfort of those being served)
Doing with and not doing to
Explaining what, why and how
Offering real choices
Flexibility
Understanding and being able to identify fight, flight and freeze responses
Focusing on strengths, not deficits
Examining power issues within the organization and promoting democratic principles (Poole, 2013)
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**Sandra Bloom M.D. (The Sanctuary Model - www.sanctuaryweb.com) identified seven commitments that trauma-informed organizations make. These are commitments to:**

- Non-violence – helping to build safety skills and a commitment to a higher purpose
- Emotional intelligence – helping to teach emotional management skills
- Social learning – helping to build cognitive skills
- Open communication – helping to overcome barriers to healthy communication, learning conflict management, reducing acting out, enhancing self-protective and self-correcting skills, teaching healthy boundaries
- Social responsibility – helping to build social connection skills, establish healthy attachment relationships, and establish a sense of fair play and justice
- Democracy – helping to create civic skills of self-control, self-discipline, and administration of a healthy authority
- Growth and change – helping to work through loss and prepare for the future

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**Trauma-informed organizations also place a priority on teaching skills in the following areas to clients, patients, residents and staff:**

- Self-soothing
- Self-trust
- Self-compassion
- Self-regulation
- Limit setting
- Communicating needs and desires
- Accurate perception of others

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## To create a climate of hope & resilience

- Acknowledge the client's abilities to survive and even grow from adversity
- Honor the strength it takes to get to where the client currently is
- Move beyond mere survival. Refer to clients as "someone who experienced trauma" – they are more than what happened to them.
- Focus on healing – recovery is possible. Let the client know that you believe in them and support their efforts to heal
- Control - Let the client decide what their path to healing will look like.

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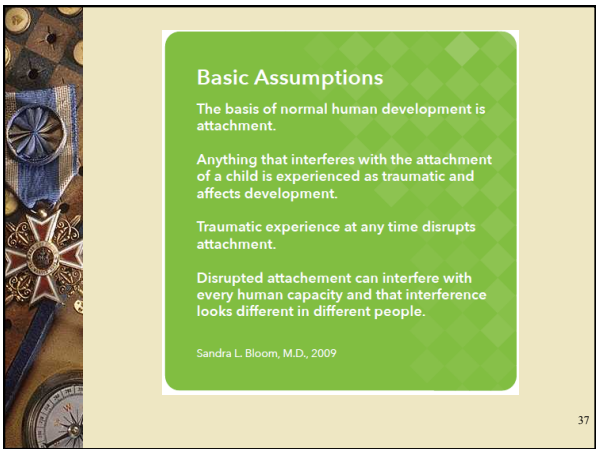
Basic Assumptions
The basis of normal human development is attachment.
Anything that interferes with the attachment of a child is experienced as traumatic and affects development.
Traumatic experience at any time disrupts attachment.
Disrupted attachement can interfere with every human capacity and that interference looks different in different people.
Sandra L. Bloom, M.D., 2009
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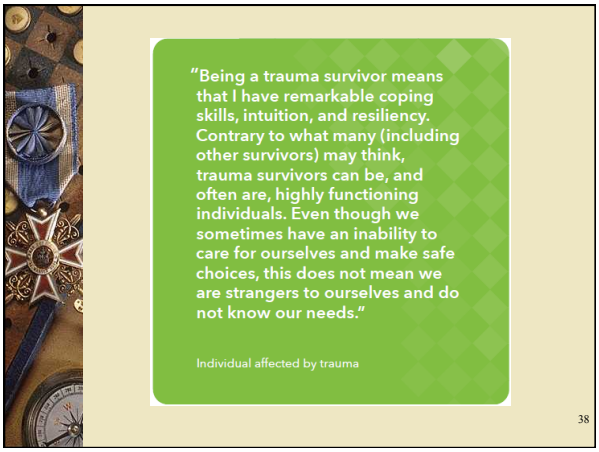
"Being a trauma survivor means that I have remarkable coping skills, intuition, and resiliency. Contrary to what many (including other survivors) may think, trauma survivors can be, and often are, highly functioning individuals. Even though we sometimes have an inability to care for ourselves and make safe choices, this does not mean we are strangers to ourselves and do not know our needs."
Individual affected by trauma
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"Focusing on their strengths engages clients in their own process of change by instilling hope about the ultimate possibility of changing and creating a better life for themselves and their family."
ARC Community Services, Madison, WI
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## We ask them to change their minds… how about us?

| | |
|---|---|
| "This person is sick." | "This person is a survivor of trauma." |
| "They are weak." | "They are stronger for having gone through the trauma." |
| "They should be over it already." | "Recovery from trauma is a process and takes time." |
| "They are making it up." | "This is hard to hear, and harder to talk about." |
| "They want attention." | "They are crying out for help." |
| "Don't ask them about it or they will get upset." | "Talking about the trauma gives people permission to heal." |
| "They have poor coping methods." | "They have survival skills that have got them to where they are now." |
| "They'll never get over it." | "People can recover from trauma." |
| "They are permanently damaged." | "They can change, learn and recover." |

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### The ABCs of Addressing Trauma Exposure Response

**A** **Awareness:**

Being attuned to one's needs, limits, emotions and resources. Heed all levels of awareness and sources of information, cognitive, intuitive and somatic. Practice mindfulness and acceptance.

**B** **Balance:**

Maintaining balance among activities, especially work, play and rest. Inner balance allows attention to all aspects of oneself.

**C** **Connection:**

Connecting with yourself, to others and to something larger. Communication is part of connection and breaks the silence of unacknowledged pain. These connections offset isolation and increase validation and hope (Health Canada, 2001).

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## What it doesn't mean

- It doesn't mean excusing or permitting unacceptable behavior.
  - Supports accountability, responsibility
- It doesn't mean just being nicer
  - Compassionate care vs TIC
  - Compassionate yes, but not a bit mushy
- It doesn't 'focus on the negative'
  - Skill-building, empowerment
  - Recognizing strengths

*Stephanie Sundborg, MS* ssund2@pdx.edu

## What is required?

- Secure, healthy adults;
- Good emotional management skills;
- Intellectual and emotional intelligence;
- Able to actively teach and be role model;
- Consistently empathetic and patient;
- Able to endure intense emotional labor;
- Self-disciplined, self-controlled, and never likely to abuse power.

*Stephanie Sundborg, MS* ssund2@pdx.edu

## The Reality

- We have a workforce that is under stress.
- We have a workforce that absorbs the trauma of the consumers.
- We have a workforce populated by trauma survivors.
- We have organizations that can be oppressive.
- All of this has an impact
  - We have organizations that come to resemble the people we're trying to help.

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## How does this play out?

- Lack of basic trust
- Loss of emotional management
- Communication breaks down
  - Interpersonal conflict arises
- Silos versus teamwork
- Repeating what doesn't work
- Loss of creative problem solving
  - Loss of participation
  - Learned helplessness
- Silencing of dissent

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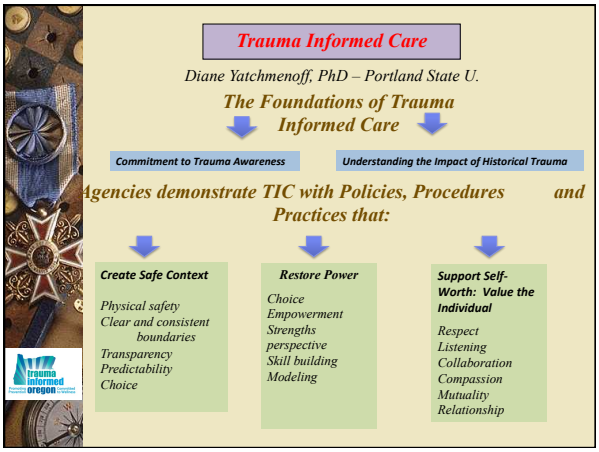
## A Parallel Process: TIC in a Nutshell

- Recognition that trauma creates fear, powerlessness, and sense of worthlessness.
- Commitment wherever possible to avoid repeating those experiences.
- INSTEAD, in whatever way possible:
  - Create safe context
  - Restore power
  - Support self-worth; value the individual

*Stephanie Sundborg, MS ssund2@pdx.edu*




## Oregon Standards of Practice for Trauma-Informed Care

- This is a voluntary initiative *which*
- Should be adapted to the needs of each organization; *meaning*
- The Standards ask for a descriptive response, rather than "yes/no". *therefore*
- The descriptors are unique to each organization, and scoring cannot be used for comparisons with other agencies

## Oregon Standards of Practice for Trauma-Informed Care *(con't)*

- The guidelines are descriptive, not prescriptive. There is no assumption that any Agency will be able to answer affirmatively in every domain.
- Agencies will respond according to their unique needs. They may be doing a number of useful strategies no captured in the guidelines

## Oregon Standards of Practice for Trauma-Informed Care *(con't)*

- It may be useful to place scores into domains according to areas of strength, and opportunities for improvement.
- Bear in mind that *(ideally)* these guidelines become manifest in individual interactions between agency, consumers and providers which personify sensitivity, respect, empowerment, transparency and caring for ALL participants *(edited mgb)*

## Let's take a look at the folks we all see most often -

- Multiple unsuccessful treatment episodes, or
- Several successful episodes of care followed by unexplained relapse;
- Clients seen in multiple treatment settings: "frequent flyers"
  - Police/jail/corrections
  - Multiple treatment providers (Bx Health, ER)
  - Multiple system clients (DHS + MH + SUD etc)

Persons with a history of complex trauma

## Common Reactions to Traumatic Stress

| | |
|---|---|
| ▪ Emotional | ▪ Physical |
| ▪ Terror | ▪ Rapid Heart Rate |
| ▪ Intense Fear | ▪ Trembling |
| ▪ Horror | ▪ Dizziness |
| ▪ Helplessness | ▪ Loss of Bladder or Bowl Control |
| ▪ Disorganized or Agitated Behavior | |

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*https://soundcloud.com/wisconsinwatch/scott-webb-trauma-informed-care*

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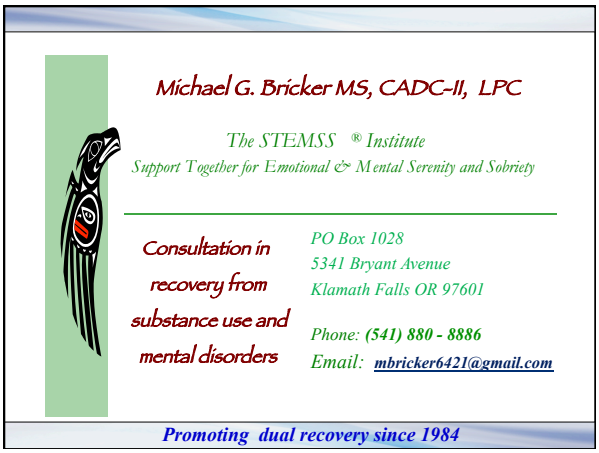
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Support Together for Emotional & Mental Serenity and Sobriety
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