Preparing the Mental Health Workforce to Succeed in Transforming Care Toward Recovery

Understanding Trauma Informed Care

NC Psychiatric Association
Pinehurst, NC
December 2, 2009

Huckshorn, Stromberg, LeBel, 2004
Revised 2006, 2007

Outline

- What is trauma?
- What is trauma informed care?
- What is the prevalence of trauma?
- What are the differences between a trauma informed and non-informed service?

What is Trauma?

- Trauma is:
  - a personal, often extreme event
  - Usually, a horrific experience
  - Impacts people profoundly
  - Redefines a person's life

Traumatic Life Events that can result in Mental Health Problems

- Are interpersonal in nature: intentional, prolonged, repeated
- Includes sexual abuse, physical abuse, severe neglect, emotional abuse
- Witnessing violence, repeated abandonment, sudden and traumatic loss
- Can occur in childhood, adolescence or at any time in an adult's lifetime

(Terr, 1991; Giller, 1999, Felitti, 1998)

Definition of Trauma Informed Care

- Healthcare staff that demonstrate:
  - An appreciation for the very high prevalence (numbers) of traumatic life experiences in persons who receive mental health services.
  - A thorough understanding of the profound neurological, biological, psychological, and social effects of trauma and violence on the individual, and

(Jennings, 2004)

How is Trauma Defined?

- NASMHPD (2004):
  - The experience of violence and victimization including sexual abuse, physical abuse, severe neglect, loss, domestic violence and/or the witnessing of violence, terrorism or disasters
- DSM IV-TR (APA, 2000):
  - Person's response involves intense fear, horror and helplessness
  - Extreme stress that overwhelms the person's capacity to cope

How is Trauma Defined?

- When trauma becomes disabling, it impacts:

1. Feelings – people are emotionally overwhelmed, fearful, anxious, and helpless
2. Thinking – people can't think clearly when stressed or manage their anxiety or distress
3. Functioning - the capacity to function in every-day-life is impaired

Remember: Trauma is not just Sexual or Physical Abuse

So, what is *"Trauma Informed Care?"*

- Care that recognizes and respects that:
  - Most people we serve have experienced serious trauma
  - Trauma experiences representsa profound loss of control
  - Trauma is not just a memory. It may have happened in the past, but it impacts the present and effects an individual's:
    - health & development, the ability to learn & function
    - Ability to have healthy relationships or trust

(Jennings, 2004)

Have many people have experienced trauma?

What about the people we serve?

What about people in other care settings?

Prevalence of Trauma
Mental Health Population – Adults

- 97% of homeless women with SMI:
  - experienced severe physical & sexual abuse
  - 87% experience abuse both in childhood and adulthood (Goodman et al, 1997)
- 90% of public mental health clients have:
  - been exposed to trauma
  - multiple experiences of trauma

  (Mueser et al, in press; Mueser et al, 1998)
- 81% of adults diagnosed BPD or DID (90%) were sexually or physically abused as children

  (Herman et al, 1989; Ross et al, 1990)
- 29-43% of people with SMI have PTSD

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

Prevalence of Trauma
Mental Health Population - Children & Adolescents

- Canadian study of 187 adolescents reported 42% had PTSD

  (Kotlek, Wilkes, & Atkinson, 1998)
- American study of 100 adolescent inpatients; 93% had trauma histories and 32% had PTSD

  (Lipschitz et al, 1999)
- A study of one state system's child/adolescent long-term care service-users (162) found 100% had documented trauma histories

  (Massachusetts DMH, 2007, in press)

Prevalence of Trauma
People with Intellectual & Developmental Disabilities

- The risk of abuse increases by 78% due to exposure to the "disabilities service system" alone (Sobsey & Doe, 1991)
- There appears to be increased vulnerability to abuse in institutional settings (White, Holland, Marsland & Oakes, 2003)
- Sexual abuse incidents are 4 times as common in institutional settings as in community (Blatt & Brown, 1986)*

*Citations from Charlton et al (2004)

Prevalence of Trauma
Substance Abuse Population

- Up to two-thirds of men and women in SA treatment report childhood abuse & neglect (SAMSHA CSAT, 2000)
- Study of male veterans in SA inpatient unit
  - 77% exposed to severe childhood trauma
  - 58% history of lifetime PTSD (Triffleman et al, 1995)
- 50% of women in SA treatment have history of rape or incest (Gov. Comm. on Sexual and Domestic Violence, Comm. of MA, 2006)

Prevalence of Trauma
Incarcerated Women

- Framingham Women's Prison, MA
  - 90% receiving mental health services or substance abuse services have trauma histories (Governor's Task Force, Comm. of MA., 2005)
- Correctional Institute for Women, RI
  - 40% - Childhood sexual abuse
  - 55% - Childhood physical abuse
  - 53% - Adult rape
  - 63% - Adult physical assault
  - 34% - Lifetime PTSD

  (Zlotnick, 1997; Zlotnick, Najavits et al, 2003)

Prevalence of Trauma
Incarcerated Youth

- 93% males in a JJ facility reported a trauma history compared to
- 84% females (84%) - but more females met criteria for PTSD (18%/females, 11%/males)

(Abram et al., 2004)

- 70% - 92% of incarcerated girls reported sexual, physical, or severe emotional abuse in childhood

(DOC, 1998, Chesney & Sheldon, 1997)

- PTSD prevalence data varies widely:
  - 3% to 50% in JJ settings and up to 8 times higher than community samples of same-age peers

(Arroyo, 2001; Garland et al, 2001; Teplin et al, 2002;. Saigh et al, 1999, Saltzman et al, 2001)

Shame & Humiliation:
A Trigger to Violence

- James Gilligan's prison research identified shame and humiliation as a core trigger to violence
- James Garbarino's research on the impact of trauma on boys identifies antisocial behavior as attempts to "regain control" through aggression
  - Denial of abuse and emotions
  - Explosion with little provocation
  - Hypersensitivity when not feeling respected

(Gilligan & Lee, 2004; Garbarino, 1999)

Shame & Humiliation
Recognizing Survival Strategies

- Garbarino's "Lost Boys" research identifies:
  - vulnerability toward feeling "shamed"
  - importance of allowing child to "save face"
  - "Juvenile vigilantism" is a survival strategy
  - Gang affiliation offers a new, better family
  - Lack of future orientation, sense of meaninglessness – tendency to take risks

(Garbarino, 1999; Hodas, 2004)

Prevalence of Trauma
Correctional Settings

Some researchers describe a pathway in which:

1. exposure to violence and
2. pervasive feelings of not being safe

develop into a state of chronic threat requiring the youth/adult to use physical aggression in order to manage these stressors. (Schwab-Stone et al, 1995)

What about people who aren't in care settings?

- Over 50% of U.S. women & 60% of men report experiencing at least 1 traumatic event at some point in their lives. But, only a minority (10% of women & 5% of men) report developing posttraumatic stress disorder, the most prominent psychiatric disorder associated with traumatic events.
  (Koenen, 2005; Kessler et al., 1995).
- More than 80% of those diagnosed with PTSD will suffer from other psychiatric disorders.
  (Solomon & Davidson, 1997)

"In my own case, growing up in an alcoholic home, I came to accept chaos as a normal state of affairs rather than the exception. I wound up sabotaging my first marriage simply because the calm left me unsettled and nervous; I had to create chaos where none existed because that's all I was familiar with." - Suzanne Somers, actress & author

Well known & not-so-well known people aren't immune from trauma

- *Housewives'* star Teri Hatcher revealed she was sexually abused by her uncle after he was arrested for molesting another girl
- Many well known and not well known people have experienced trauma

Other Current Trauma Research

Current research has focused on the effects of childhood trauma on adult behaviors:

- Adverse Childhood Events (ACES) have serious health consequences
- People appear to adopt risky health behaviors as coping mechanisms in adulthood, including:
  - eating disorders, smoking, substance abuse, self harm, sexual promiscuity
- These behaviors result in:
  - Severe medical conditions: heart disease, pulmonary disease, liver disease, STDs, GYN cancer, early death

(Felitti et al, 1998)

What does all of this mean?

- Most of the people served in:
  - psychiatric treatment settings have trauma histories
  - prison or juvenile justice systems have trauma histories
- Many people served in other care systems have experienced trauma
- People who are not in care settings may also experience trauma – that means staff, too
- ***What's the difference?*** The extent to which it impairs a person's ability to function

(Hodas, 2004, Frueh et al, 2005; Mueser et al, 1998; Lipschitz et al., 1999; NASMHPD, 1998)

What if you don't know if someone has a trauma history?

Take a *"universal precautions"* approach – assume **everyone** we serve has a history of trauma

(Hodas, 2004)

Universal Precautions

- These kinds of 'precautions' are aimed at *preventing* illness or injury before they take place
- Like hand washing techniques to avoid passing on colds or using condoms for 'safe sex'
- In the trauma informed setting, this means using interventions to avoid conflict, violence, assure safety, meet needs and minimize any traumatic event that could hurt clients or staff

(NETI, 2005)

"If you can, help others;
if you cannot do that,
at least do not harm them."

- Dalai Lama

"Kindness is a language that the deaf can hear and the blind can see."

- Mark Twain

What does a Trauma Informed Care System Look Like?

Trauma Informed Care System: Key Principles

- Uses intervention based on current literature
- Is informed by research and evidence of effective practice
- Recognizes that coercive interventions cause traumatization and re-traumatization and are to be avoided

(Fallot & Harris, 2002; Ford, 2003; Najavits, 2003)

Trauma Informed / Non Trauma Informed

How would trauma be recognized?

Trauma Informed

- Recognition of high prevalence of trauma
- Life history is appreciated/recorded
- Assess for Traumatic Histories & Symptoms
- Recognition of setting/culture and practices that are re-traumatizing

Non Trauma Informed

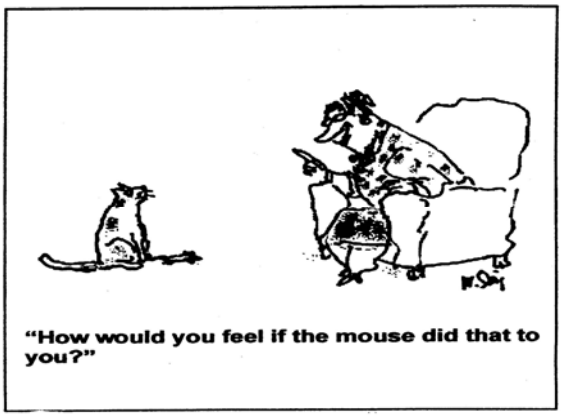
- Lack of education on trauma prevalence & "universal" precautions
- Person seen without family/social history
- Cursory or no Trauma Assessment
- "Tradition of Toughness" valued as best care approach

A Trauma Informed Service Recognizes:

"Any intervention that recreates aspects of previous traumatic experiences or that uses power to punish is harmful to the individual involved"

(NASMHPD, 1998)

Trauma Informed	**Non Trauma Informed**
How would the service feel?	
▪ Power/Control is minimized - constant attention to practices	▪ Keys, Security Uniforms, staff demeanor, authoritative tone of voice
Language	
▪ Counselors, Staff	▪ Techs, Guards
▪ Caregivers/Supporters – ***Collaboration***	▪ Rule Enforcers – ***Compliance***
▪ Address training needs of staff to improve knowledge & sensitivity	▪ "Patient-blaming" as *fallback* position without training



"How would you feel if the mouse did that to you?"

Trauma Informed	Non Trauma Informed
How would people be respected?	
▪ Understand function of behavior (rage, repetition-compulsion, self-injury)	▪ Behavior seen as intentionally provocative & volitional
▪ Objective, neutral language	▪ Labeling language: manipulative, needy, gamey, "attention-seeking"
▪ Consumer is center of their treatment	▪ Lack of self-directed care
▪ Transparent systems open to outside parties	▪ Closed system – advocates discouraged

(Fallot & Harris, 2002; Cook et al, 2002; Ford, 2003; Frueh et al, 2005; Jennings, 1998; Prescott, 2000)

Trauma Informed	Non Trauma Informed
What would you hear?	
▪ Asking people how they prefer to be addressed	▪ Calling people by first name without permission or last name w/out title
▪ Quietly making rounds and informing people of schedule	▪ Yelling "lunch" or "medications"
▪ *"Let's talk and find you something to do"*	▪ *"If I have to tell you one more time …."*
▪ *"May I help you?"*	▪ *"Step away from the desk"*

Trauma Informed	Non Trauma Informed
What would you see?	
▪ Modified nursing station without barrier – welcoming and open	▪ Large Barrier around nursing station – "Us/Them"
▪ Checks to check-in with the person – eye contact	▪ Checks to simply locate – focus on task, not person
▪ Saying hello and goodbye at beginning and end of shift	▪ Coming in and leaving without acknowledgement

The Importance of
Carefully Assessing Trauma

Why is Trauma Assessed?

- A more sensitive review of someone's trauma history should be done respectfully and shortly after admission in order to:
  - Identify past or current trauma, violence, abuse experiences
  - Learn how trauma is expressed when the person is under duress
  - Incorporate this information into an individualized, person-specific care plan

(Cook et al, 2002; Fallot & Harris, 2002; Maine BDS, 2000)

Common Trauma Symptoms People Struggle With

- Dissociation
- Flashbacks
- Nightmares
- Hyper-vigilance
- Terror
- Anxiety
- Negative auditory hallucinations
- Numbness,
- Depression
- Substance abuse
- Self-injury
- Eating problems
- Sexual promiscuity
- Poor judgment and continued cycle of victimization

(DSM IV-TR, 2000)

Trauma Assessment
Components

- ***Type***
  - sexual, physical, emotional, neglect, witnessed domestic violence, exposure to disaster, combat exposure, other
- ***Age***
  - When the abuse occurred is important in terms of the impact on the person's development
- ***Who***
  - Was abuser a stranger? Family member?

(Carmen et al, 1996)

"The greater the power, the more dangerous the abuse."

- Edmund Burke

Trauma Assessment:
Key Principles

- Focus on "*what happened to you*" instead of "*what is wrong with you*"

(Bloom, 2002)

- Begin to develop a a therapeutic relationship (trust, respect, caring) during this process
- Create a crisis/safety plan to use in the hospital/care setting to learn and practice new self-calming skills

Trauma Assessment:
Key Principles

- Information from the assessment and *"positive responses"* to current abuse questions must be incorporated into treatment and discharge plans or the assessment has no value
- Also, if previously disclosed, what happened? Ask if the person has ever told anyone, at all…

When Anne Heche Disclosed

"I told my mother at about the seventh year of therapy that I had been abused sexually by my father, and she hung up the phone on me."

"When a victim reaches out for help or reports the abuse, she/he is often re-victimized by a society who doesn't want to hear what they need to hear. The re-victimization leaves long lasting emotional scars and "cuts deep wounds" in the victim's psyche." Coral Anika Theill

In Summary…..

- Most of the people in our care have been traumatized
- When stressed, past trauma comes to the present
- Crisis symptoms are survival strategies
- Try to understand the consumer's history and how to support efforts to teach self-calming
- Practices that take away control and choice can be traumatizing
- Watch for trauma "uninformed" practice and try to prevent, avoid or eliminate it
- Keep asking – *is what I am doing respectful and trauma-informed?*

"I have learned two lessons in my life:

first, there are no sufficient literary, psychological, or historical answers to human tragedy, only moral ones.

Second, just as despair can come to one another only from other human beings, hope, too, can be given to one only by other human beings."

- Elie Wiesel, Author & Holocaust Survivor