1

Laying the Foundation: *Essential Concepts in Trauma-Responsive Care*

ANGELA LEWIS-DMELLO, MSW, LICSW

1

2

Objectives

Recognize	*Recognize the effects of traumatic experiences on clients and the prevalence of those effects in the individuals with whom I work*
Learn	*Learn different forms of trauma and the impact of trauma across the lifespan, including the Adverse Childhood Experiences research.*
Identify	*Identify concrete strategies for providing trauma responsive care*

2

3

- What is trauma?
- What is trauma – informed/trauma-responsive care?
- How or why might it be beneficial to make trauma-responsive care an organizational value and mandate rather than an individual employee decision?

3

4

Trauma Defined: DSM-5 Criterion A

- The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (1 required)
  - Direct exposure.
  - Witnessing, in person.
  - Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
  - Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

4

Symptoms

- **Intrusion symptoms:** intrusive memories, nightmares, flashbacks, psychological or physiological distress with cue
- **Avoidance:** memories, thoughts, feelings, or people, places, situations, etc.
- **Negative alteration in cognition and mood:** not remembering part of event, negative beliefs, distorted cognitions (self blame), negative emotions, less interest in activities, detachment from others, can't feel positive emotions
- **Arousal:** irritability and angry outbursts, reckless behavior, hypervigilance, exaggerated startle response, problems concentrating, difficulty sleeping

5

6

Types of Trauma

- Simple or Single Incident Trauma (Type I)
  - A single isolated event that occurs in the context of relative emotional and physical safety.

6

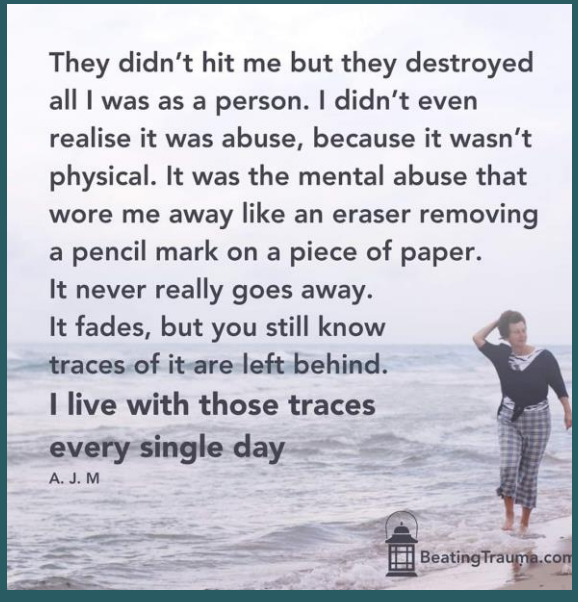
7

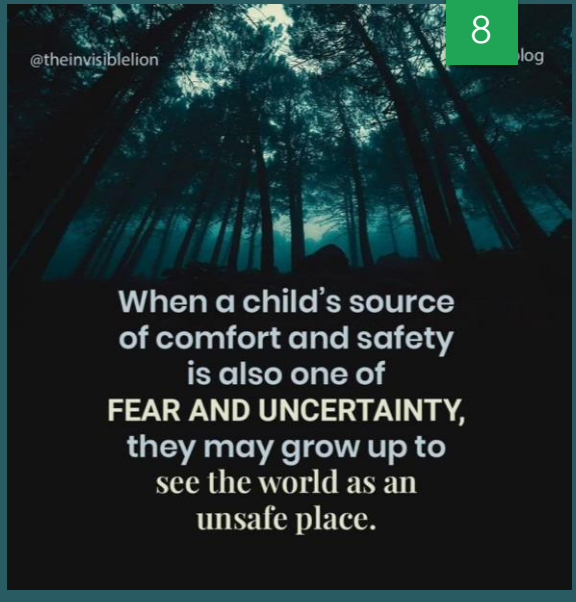
Types of Trauma

- Complex or Developmental Trauma (Type II)
  - In environment of maltreatment and neglect
  - Ongoing, unrelenting, negative experiences
  - Chronic, generally interpersonal, exposure
  - Usually during early development

7

8





8

9

Types of Trauma

- Historical Trauma
- Intergenerational Trauma
- Family of Origin Trauma – Physical and Emotional Abuse; Neglect
- Domestic Violence (Experiencing or Witnessing)
- Community Violence/Gang Violence
- Hate Crime
- Sexual Assault and Child Sexual Abuse
- War Trauma - Veterans
- Refugee/Immigrant Populations (War, Famine, IDPs)
- Participation Induced
- Secondary Trauma
- Natural Disasters, Car Accidents, Animal Bite
- Medical Trauma

9

10

Historical/Transgenerational Trauma

a context of societal trauma. Societal trauma is also referenced as intergenerational trauma, race-based trauma, sexism, racism, classism, heterosexism, historical trauma, insidious trauma, cultural violence, political and racial terror, and oppression (Bryant-Davis & Ocampo, 2006; Carter, 2007; Root, 1992; Taylor, 2005; Tummala-Narra, 2005; Whitbeck, Adams, Hoyt, & Chen, 2004). Societal traumas are viewed as interpersonal and systemic emotional, verbal, and physical assaults by those with power and privilege against members of marginalized group. These acts, intentional or nonintentional,

10

11

Historical/Transgenerational Trauma

- Historical Trauma and Microaggressions: A Framework for Culturally-Based Practice
  - Historical trauma is defined by Brave Heart as "a constellation of characteristics associated with massive cumulative group trauma across generations".
  - Microaggressions "serve to connect [the individual] with a collective and often historical sense of injustice and trauma"

11

12

Adverse Childhood Experiences

12

13

Adverse Childhood Experiences

- ACE study: CA
  - Examines the health and social effects of ACEs throughout lifespan
  - Studied among 17,337 members of the Kaiser Health Plan in San Diego County from 1995-1997
  - Family Health History and Health Appraisal Questionnaires

13

14

Adverse Childhood Experiences

- Physical abuse
- Sexual abuse
- Verbal abuse
- Mental illness of a household member
- Problematic drinking or alcoholism of a household member
- Illegal street or prescription drug use of a household member
- Divorce or separation of a parent
- Domestic violence towards a parent
- Incarceration of a household member
- (Neglect – added later)

14

California Findings

15

ACE Category	Total Percent (N = 17,337)
ABUSE	
Emotional Abuse	10.6%
Physical Abuse	28.3%
Sexual Abuse	20.7%
HOUSEHOLD CHALLENGES	
Mother Treated Violently	12.7%
Household Substance Abuse	26.9%
Household Mental Illness	19.4%
Parental Separation or Divorce	23.3%
Incarcerated Household Member	4.7%
NEGLECT	
Emotional Neglect[3]	14.8%
Physical Neglect[3]	9.9%

Number of Adverse Childhood Experiences (ACE Score)	Total Percent (N = 17,337)
0	36.1%
1	26.0%
2	15.9%
3	9.5%
4 or more	12.5%

Note: [3]Collected during Wave 2 only (N=8,629). Research papers that use Wave 1 and/or Wave 2 data may contain slightly different prevalence estimates.

15

ACE - MN

16

- ACE study: MN
  - 2011 telephone survey of 13,520 people
  - 55% had at least one ACE
  - 60% of those with one had more than one
  - Frequency:
    - Emotional Abuse = 28%
    - Alcohol Abuse in home: 24%
    - Separation or Divorce of Parent: 21%
    - Mental Illness in home: 17%
    - Physical Abuse: 16%

16

17

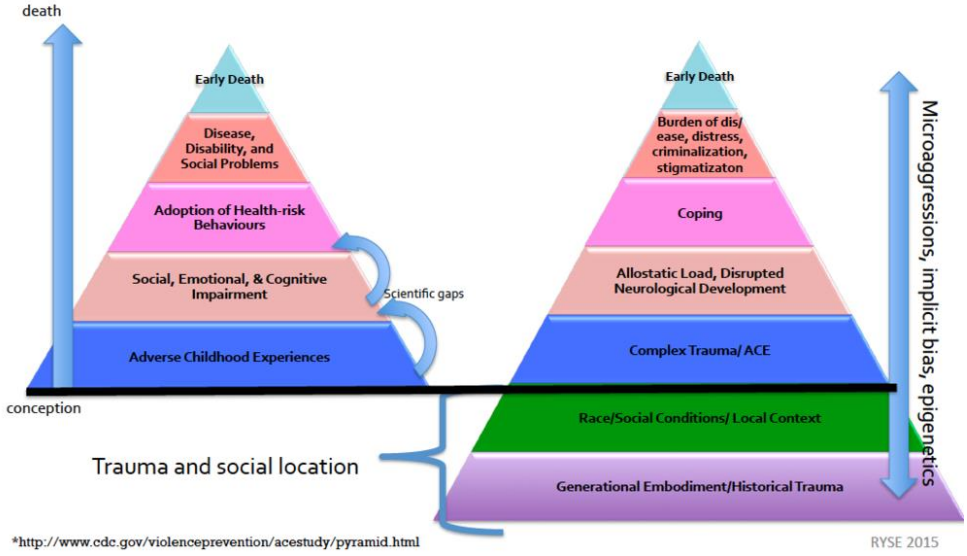
Adverse Childhood Experiences

The Adverse Childhood Experiences (ACE) Study is "epidemiological" in nature. That is to say, it focuses on the public health aspects of disease, where it occurs, who is at risk, and measures the extent to which childhood trauma translates into poor health and social well-being later in life. As such, the ACE Study clearly demonstrates that children—and the adults we become—have long been "paying the piper" for the deeds of our parents, and others who perpetrate child abuse.
http://acestudy.org/download

17

Trauma and Social Location

8



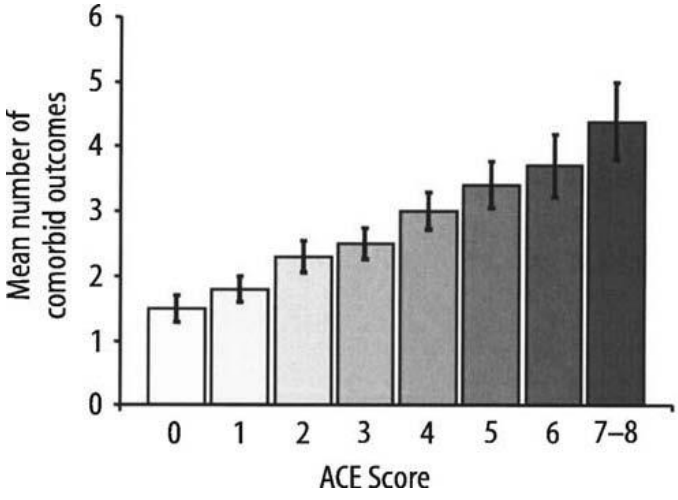
18

Adverse Childhood Experiences

ACEs increase the risk of:

- Early death
- Heart Disease
- Chronic Lung disease
- Lung Cancer
- Liver disease
- Suicide
- Injuries
- HIV and STDs
- Autoimmune conditions
- Asthma
- Diabetes
- Obesity
- Depression
- Anxiety
- Chronic Drinking
- Current Smoking
- Fair or Poor Health Status

19



20

Adverse Childhood Experiences

20

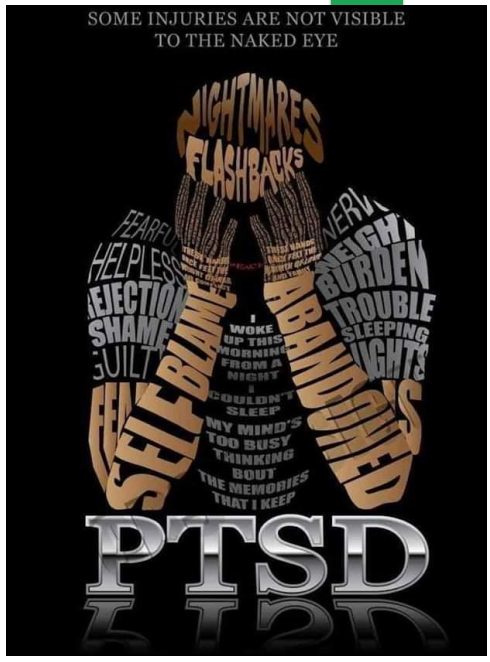
21

More Deeply Understanding Trauma

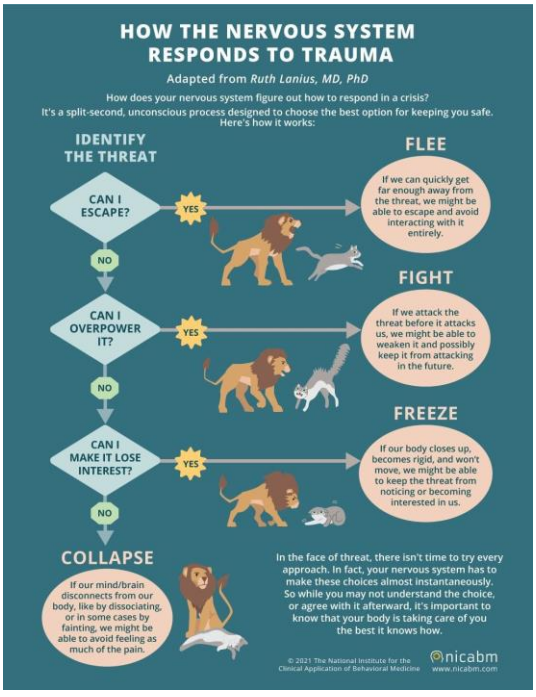
21

Core Experience of Trauma

- Disempowerment
- Helplessness
- Disconnection
- Repetition of past/Stuck in past
- Lack of choice

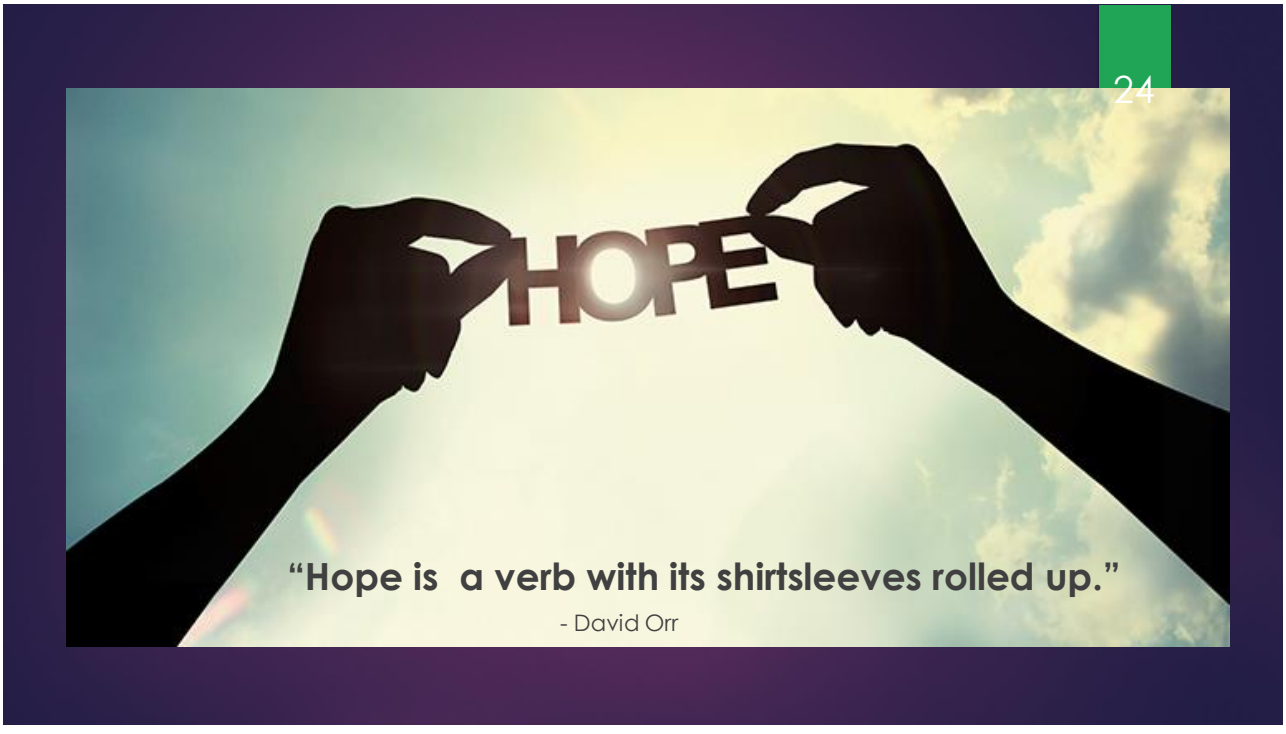


22


HOW THE NERVOUS SYSTEM RESPONDS TO TRAUMA
Adapted from Ruth Lanius, MD, PhD
How does your nervous system figure out how to respond in a crisis?
It's a split-second, unconscious process designed to choose the best option for keeping you safe. Here's how it works:
IDENTIFY THE THREAT
CAN I ESCAPE?
YES
FLEE
If we can quickly get far enough away from the threat, we might be able to escape and avoid interacting with it entirely.
NO
CAN I OVERPOWER IT?
YES
FIGHT
If we attack the threat before it attacks us, we might be able to weaken it and possibly keep it from attacking in the future.
NO
CAN I MAKE IT LOSE INTEREST?
YES
FREEZE
If our body closes up, becomes rigid, and won't move, we might be able to keep the threat from noticing or becoming interested in us.
NO
COLLAPSE
If our mind/brain disconnects from our body, like by dissociating, or in some cases by fainting, we might be able to avoid feeling as much of the pain.
In the face of threat, there isn't time to try every approach. In fact, your nervous system has to make these choices almost instantaneously. So while you may not understand the choice, or agree with it afterward, it's important to know that your body is taking care of you the best it knows how.
© 2021 The National Institute for the Clinical Application of Behavioral Medicine
nicabm
www.nicabm.com


HOW TO DIFFERENTIATE FREEZE FROM SHUTDOWN
Freeze and collapse both involve the inability to move. But while they might appear similar, they are very different physiological responses to stress or trauma.
Here are some key differences:
VS.
FREEZE
The client is HYPERaroused.
The muscles are tense and full of energy, but can't release it.
In this stage, there are similar levels of sympathetic and parasympathetic activation.
Increased heart rate/blood pressure
The client might say, "I feel stuck," "I can't move," or "I feel like I am encased in cement."
Eyes widen
The body is ready to return to fight/flight as soon as the threat passes.
SHUTDOWN/COLLAPSE
The client is HYPOaroused.
The muscles are flaccid and loose.
The parasympathetic nervous system is dominant.
Decreased heart rate/blood pressure/temperature
The client may not be able to speak at all.
Blank stare
Sensory info stops at the thalamus. It doesn't reach the cortex (so it's not integrated). The client is less aware of their internal and external world.
Endorphins release to numb pain. Dynorphins release, which can make the client feel detached from their body.
Can result in fainting
Knowing the differences between these two responses can help you determine which therapeutic strategies you should use with a given patient.
nicabm
www.nicabm.com
© 2020 The National Institute for the Clinical Application of Behavioral Medicine

23


24
HOPE
"Hope is a verb with its shirtsleeves rolled up."
- David Orr

24

25

Trauma-Informed Practices

"...Trauma-informed [practices are] grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and interpersonal violence and the prevalence of these experiences in persons who receive [mental health (and other)] services.

It involves not only changing assumptions about how we organize and provide services, but creates organizational cultures that are personal, holistic, creative, open, and therapeutic. A trauma-based approach primarily views the individual as having been harmed by something or someone: thus connecting the personal and the socio-political environments".

Dr. Sandra Bloom (1997)

25

26

SAMHSA'S Definition

"A program, organization, or system that is trauma-informed:

- *Realizes* the widespread impact of trauma and understands potential paths for recovery;
- *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
- Seeks to actively resist *re-traumatization*."

26

27

The Care Continuum

- Trauma-responsive care occurs from the moment a client makes their first call and with *every* individual they come in contact with from that moment until they terminate services.
- Trauma responsive care requires re-writing programs from start to finish incorporating trauma theory and neuroscience research into both process and content
- Trauma-responsive care requires physical changes to the environment and organizational culture where services are provided.
- Trauma responsive care requires a focus on resiliency, strength, healing, and community/connection

27

28

Judith Herman's Triphasic Model

Stage	Objective
Stage 1	Safety and Stabilization
Stage 2	Remembrance
	Mourning
Stage 3	Reconnection

28

29

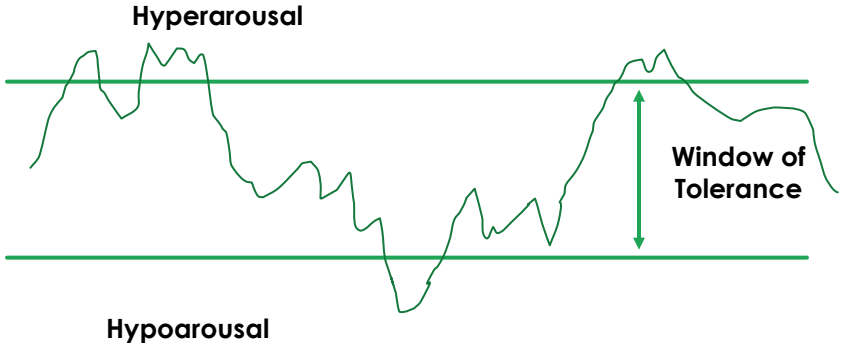
Key Ingredients of Trauma-Informed Practices

- Safety
- Self-regulation & Coregulation
- Self-reflective information processing
- Traumatic experiences integration
- Relational engagement
- Positive affect enhancement

29

30

Window of Tolerance (Siegel, 1999)



30

31

Stage 1: Safety & Stabilization

- Engaging the Care Continuum
  - Advocacy and Legal Support
  - Shelter or Safe Housing
  - Case Management/Basic Needs
  - Medical, Psychiatric, Dental
  - Psychotherapy

31

32

Stage 1: Safety & Stabilization

- Within Services
  - Intake Assessment to determine fit for services
  - Orientation to Physical Environment
  - Education – system, services, psycho-ed, etc.
  - Choice : self-determine engagement and level of openness
  - Safety planning when appropriate

32

Safety and Stabilization Assessment

33

- Is the survivor's body okay, or do they need medical care?
- Is the survivor able to care for themselves and their safety - intoxication, TBI, delirium, dissociation, severe psychosis?
- Do they have suicidal thoughts, intent, plan, means?
- Do they have homicidal thoughts, intent, plan, means?
- Is the survivor's current psychosocial environment safe?

33

What survivors need from their providers in *Safety and Stabilization*

34

- Time! Go slow here…
- Non-assumptive approach
- Talk explicitly and specifically about privacy and boundaries with examples
- Work with what they want and need first – their agenda is always more important than yours

34

35

What survivors need from their providers in *Safety and Stabilization*

- Normalization
  - What happened isn't "normal" but their responses ARE
- Transparency
  - I say, I do, I say what I did
  - I explain my actions with why
- Ensure medical needs are managed through referrals (so they don't overwhelm)
- They should not re-experience (vs. remembering) their trauma as it makes the environment (and providers) feel unsafe

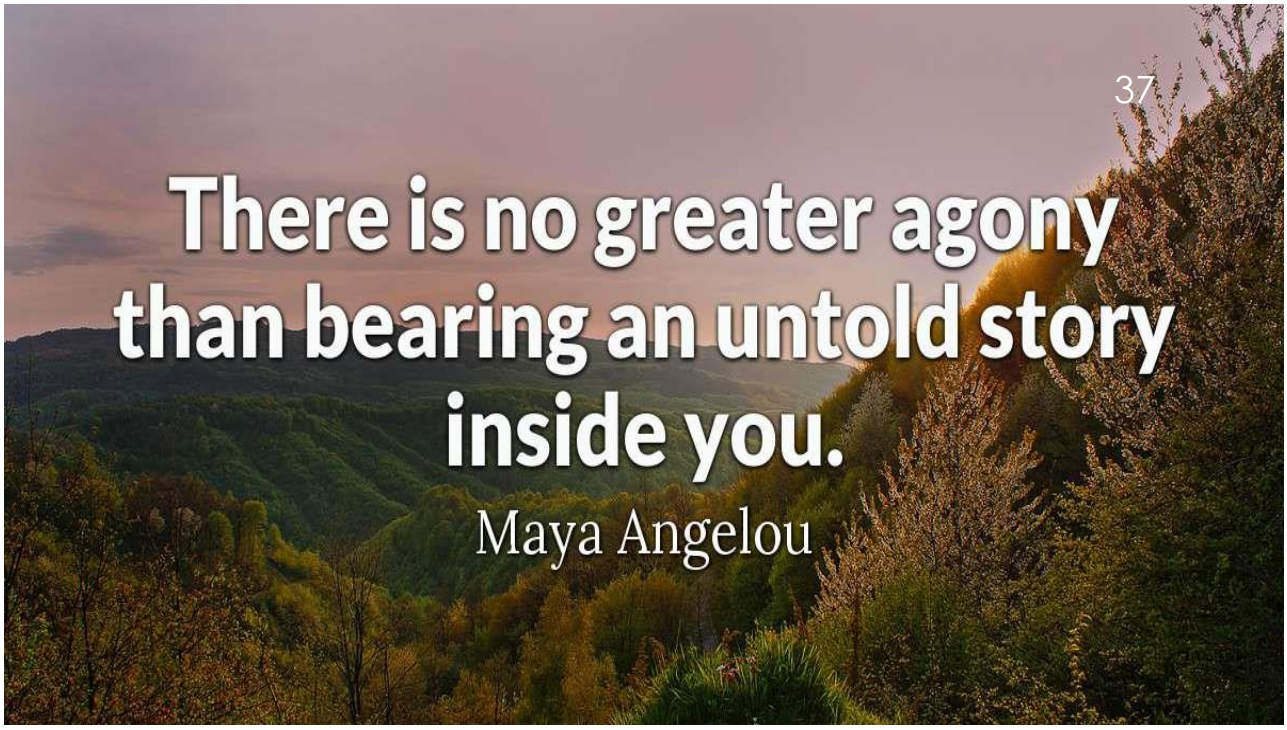
35

36

Stage 2: Remembrance

- Creating a linear, coherent narrative, grieving multiple losses, and making meaning out of their experiences of trauma
- Requires safety and stability to keep client safe and from decompensating
- Ongoing trauma of court involvement (repeated telling's)
- This portion of services frequently sees an increase in symptoms, including impulsive symptoms, anger and aggressiveness, and alcohol & substance use

36



37

Stage 2: Mourning

38

- Many different experiences of loss
  - Loss of identity
  - Loss of place
  - Loss of ideal future
  - Loss of a Good/Safe World/Other
- Griefwork

38

39

What survivors need from their providers in *Remembrance and Mourning*

- Empathy NOT sympathy
- Clear and assertive communication; matter-of-fact tone of voice
- Assume that it is the trauma/their extreme level of stress first, rather than a personal defect
- Validate their perceptions of the world

39

40

What survivors need from their providers in *Remembrance and Mourning*

- Don't blame them for their trauma experience (like society often does)
- Don't silence the shame, embarrassment, anger, or hopelessness
- Be curious about them. What does it feel like to be them? See through their eyes? Feel in their body?
- Each individual has own experience of trauma - no one else can intimately "know"

40

41

Restoring Connections

Self	*Social Support/ Community*	*Meaning Making*
Identity	Healthy Romantic Relationships	Advocacy/Research/ Policy
Body- Noticing Responses, Befriending, Creating Safety	Supportive Friends and Family	Existential/Spiritual
Internal Locus of Control	Places of Belonging and other Community Resources	The Arts

41

42

What survivors need from their providers in *Restoring Connections*

- Take their ailments seriously
- Support and attention to adequate sleep/nutrition/exercise
- Talk about feelings and fears of services
- Do it WITH them rather than FOR them
- Remind them that their care (or level of engagement) is voluntary and that you want your service to work/help
- Acknowledge that their sense of safety and trust has been violated by the world

42

43

Posttraumatic Growth

- Term coined by Richard Tedeschi in mid-90's
- Positive change experienced as the result of traumatic experiences
- Never wish trauma upon anyone, but the growth that can occur as a result is profound
- Movement beyond pre-trauma levels of functioning (not just resisting negative change otherwise known as resilience)
  - new opportunities or possibilities in life
  - increased sense of personal strength
  - change in relationships with others
  - greater appreciation for life in general
  - deepening of spiritual life
- Requires a period of intense self-reflection after trauma processing

43

44

It's the little things…

- Eye contact
- Soft voice
- Walk side by side or in front of them (not behind)
- Warm smiles
- Have a view of and access to the door
- Can keep the door open
- Not a square, sterile space
- Let them lead - have control

44

45

It's the little things…

- Talk about privacy and boundaries
- Slow them down
- Contain their narratives (rephrase, reduce intensity, be present)
- Reframe previously unwanted symptoms (i.e. anger, shame) as heroes of their story
- They should not re-experience (vs. remembering) their trauma with their provider - 1x is too many

45

46

"No intervention that takes power away from the survivor can possibly foster her recovery, no matter how much it appears to be in her immediate best interest."

-Judith Hermann

46