Trauma-Informed Care

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Irene Njoroge RN, BScN, MPH(C) & Leslie Molnar MSW RSW
Women's College Hospital

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Health care for women | REVOLUTIONIZED

Presenter Disclosures

Presenter name: **Irene Njoroge, Leslie Molnar**

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Objectives

1. Provide background information on the connection between impacts of trauma and substance use issues

2. Define trauma-informed care and what it means for the RAAM clinic

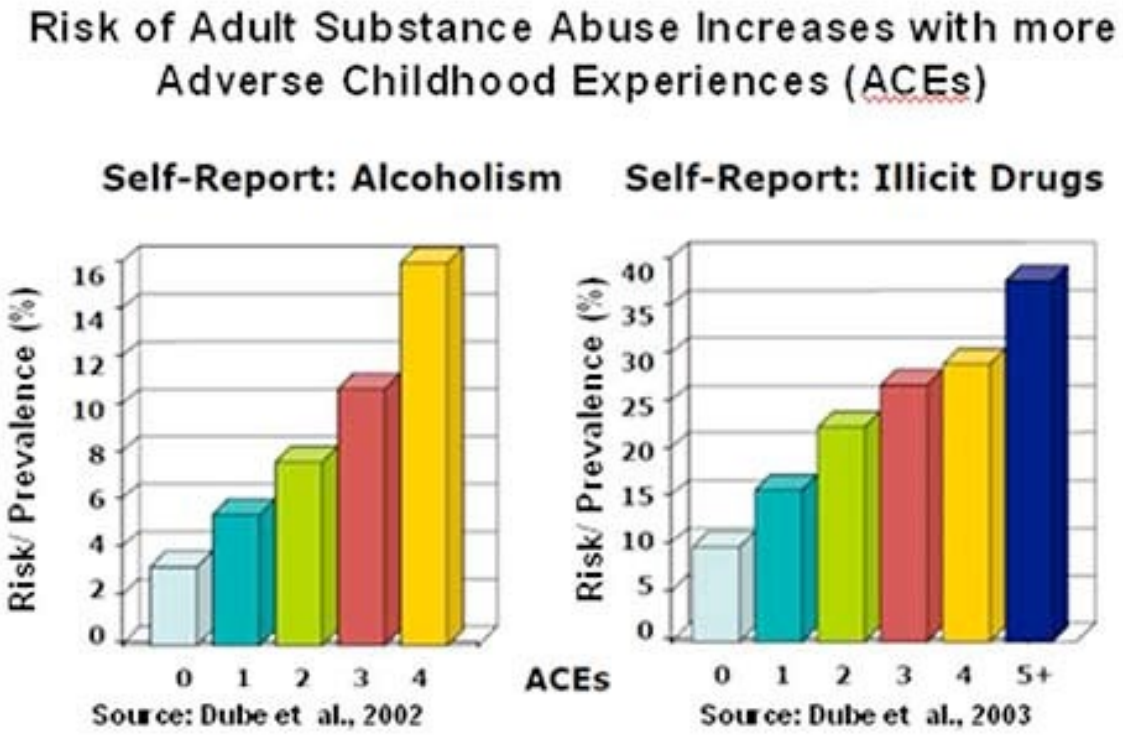
3. Understand key information around trauma and how to assess

4. Learn techniques on how to support RAAM clients with trauma histories

ACEs study

- The 17,337 participants were volunteers from approximately 26,000 consecutive Kaiser Permanente members.
- 1995 to 1997 (published 1998)
- About half were female, 74.8% were white, average age was 57
- 75.2 had attended college
- All had jobs and good health care
- Linked to health conditions
- For numerous health conditions response to ACEs was strong and graded

Current AUD, lifetime drug use



http://www.cdc.gov/violenceprevention/acestudy/outcomes.html

5 main discoveries

1. ACEs are common…nearly two-thirds (64%) of adults have at least one.

1. The more ACEs you have, the greater the risk for chronic disease, mental illness, violence and being a victim of violence. People with a score of 4 are twice as likely to be smokers and 7 times more likely to be alcoholic.

1. ACEs don't occur alone….if you have one, there's an 87% chance that you have two or more.

1. ACEs are responsible for a big chunk of workplace absenteeism, and for costs in health care, emergency response, mental health and criminal justice.

1. Childhood adversity contributes to most of our major chronic health, mental health, economic health and social health issues.

http://www.cdc.gov/violenceprevention /acestudy/about.html

Why do ACEs increase addiction risk?

- Estimated that ACEs were responsible for at least **1/2 to 2/3** of drug addictions
- Those with history of ACEs have abnormal neuro-development:
  - Dysfunction in dopamine and serotonin pathways
  - Problems with affect-regulation, attachment, identity, relationships, sense of meaning
  - High levels of anxiety, depression, suicidality
  - Rarely feel at ease and relaxed
- Dopamine pathways: Reward, pleasure, salience
  - Dopamine release from many psychoactive substances
  - Prone to misuse is often 5-10x greater than physiological (food, sex, companionship)
  - For the first time ever, it is enough for those with trauma to feel happy, at ease
    - "Two drinks short of normal"
    - Coping mechanism
  - However, over time brain responds by decreasing dopamine release and dopamine receptors (also changes in other pathways)
    - Leads to tolerance and withdrawal

TRAUMA

“When you have a persistent sense of heartbreak and gut-wrench, the physical sensations become intolerable and we will do anything to make those feelings disappear. And that is really the origin of what happens in human pathology. People take drugs to make it disappear, and they cut themselves to make it disappear, and they starve themselves to make it disappear, and they have sex with anyone who comes along to make it disappear and once you have these horrible sensations in your body, you’ll do anything to make it go away.”
— Bessel A. van der Kolk

Definitions

Trauma:

- An out-of-control frightening event/situation
- Overwhelms an individual's resources for coping and functioning
- Creates fear, horror and helplessness

Multi-generational trauma:

- Trauma experienced by parents has an impact on children
- Effects on attachment and identity
- Examples: Children of holocaust survivors, parents who have experienced sexual, physical, emotional abuse, children of parents who were in residential school system
  - 1850s to 1990s approximately 150,000 First Nation, Inuit, and Metis children were removed from their homes and placed in government boarding schools
  - Separation from family, culture
  - Experienced physical abuse, neglect, sexual abuse
  - Traumatic to whole communities - those left behind as well

Impacts

- Can profoundly affect how an individual views the world/interacts with others
- Can have lifelong impacts - most damaging is repetitive, interpersonal, younger
- Two people can experience the same event differently:
  - Past experiences
  - Previous traumas
  - Mental health/current state
  - Supports: ACEs study
- Victims of interpersonal traumas are at higher risk of experiencing more interpersonal traumas
  - Underlying factors make them more vulnerable: Mental health disorders, substance use disorders, survival sex work/crime, genetic/epigenetic factors
  - Effects of trauma itself: Loss of stability/safety, abnormal neuro-development, mental health problems (PTSD), substance use - coping mechanism

Dr. Gabor Mate: “These are the abused children we had so much compassion for, but as adults we treat them as criminals.”

Case – Trish (1)

Situation

- 18yo woman
- Moved to Toronto several months ago from Nova Scotia to escape abusive pas
- Stayed with friend, but since left due to conflict
- On the street, “couch surfing”, involved in sex-trade
- Trying to secure housing

Family Hx

- Youngest of 3
- Left school at 15yo when started experiencing flashbacks of childhood sexual abuse
- Ran away at 17yo; no family contact since then
- Limited financial resources, no social supports

Substance Use Hx

- Alcohol and marijuana since early adolescence, currently using numerous street drugs including heroin

Case – Trish (2)

Assessment

- Hx of childhood abuse and family substance use
- Sexually abused by mother's ex-boyfriend
- Emotional abuse by mother, physical abuse by eldest brother

Mental Health Hx

- BPD diagnosed at 16 yrs during hospitaliztion for self-harm
- Self-harm continues "this is the only way I feel real, I feel numb most of the time"
- Ongoing struggles with flashbacks, poor sleep, restrictive eating, anxiety, low mood
- "smoking pot helps"
- No previous therapy or counselling

Case - Questions

1. What areas of concern do you address first?

2. How do you develop an alliance with Trish?

3. What do you see are her strengths? Her challenges?

4. What strategies might work to create a healing experience for Trish?

Trauma-Informed Care

Complex Trauma

- Effects of prolonged and repetitive interpersonal trauma beginning at an early age, with perceived or actual inability to escape
- Most severe symptoms: PTSD symptoms, self-harm, chronic suicidality, addictions, “difficult” behaviors: examples…
- Result of abnormal neuro-development
- Coping in ways that are somewhat effective (at least in short-term)
- Coping with complicated lives: Addictions, mental health problems (PTSD, depression), poverty, ongoing trauma…
- Missed/late for appointments, frequent use of emergency services, unreasonable demands, non-compliant with treatment, angry, aggressive, violent, dependent

PTSD Symptoms:

- Re-experience the event through flashbacks, dreams, intrusive thoughts, cues in the environment
- Avoidance of stimuli that might provoke re-experiences
- Negative effect on cognition and mood
- Increased arousal (difficulty falling asleep, anger, hyper-vigilance…)
- Impact on daily functioning

Definitions

Trauma-informed care:

- Organizational structure and treatment framework that involves:
  - Understanding, Recognizing, Responding - to the effects of all types of trauma
  - Emphasizes physical, psychological, emotional safety for consumers and providers
- Helps survivors rebuild a sense of control and empowerment

Trauma-informed services: take into account knowledge of the impact of trauma and integrate this knowledge into all aspects of service delivery.

- "Problem behaviours" are understood as attempts to cope with abusive experiences.
- **Disorders become responses, and symptoms become adaptations**
- Shifts the conversation from "What is wrong with you?" to "What has happened to you?"

"Gendering the National Framework" discussion guide sponsored by the British Columbia Centre of Excellence for Women's Health (BCCEWH) in partnership with the Canadian Centre on Substance Abuse (CCSA) and the Universities of Saskatchewan and South Australia.

Trauma specific services:

- Reduces drop-out rates (Elliot 2005)
- Encourages help-seeking (Brown 2000)

Core principles

Acknowledgment

- Recognize that trauma is pervasive and communicate this

Trust

- Be open, honest about your skills, knowledge, limitations
- System should be transparent, accommodating, consistent boundaries

Collaboration

- Choice and control
- All aspects of engagement with the healthcare system

Compassion

Strengths-based

- Acknowledge resilience and that methods of coping are understandable/logical

Safety

- Emotional safety: Avoid re-traumatizing
- Help keep patients safe from self-harm: Have a safety plan
- Building should be physically safe: Lit, secure

Screening for trauma

- Based on the research (ACEs Study) demonstrating the relationship between traumatization and negative health consequences, it is healthcare provider's "business" to ask
- Leave it up to the patient to decide if they disclose or not
- Communicate awareness, belief that it's important and have a willingness to hear
- Opens the door
- Specialized trauma care shown to improve outcomes
- Universal screening is recommended

Clark, Classen, Fourt, Shetty – *Treating the Trauma Survivor, 2015*

Health care providers express the following worries:

- *I won't know how to respond*
- *It's none of my business*
- *I don't know how to ask*
- *I won't have the time to hear the whole story*
- *I don't have the skill set and will make things worse*
- *I may respond with emotion/ hard to hear/ reminders of own struggles*
- *What if they become too emotional?*
- *I don't think it's the right time to ask about trauma*

Asking and informing

- Be prepared to provide information and/or define trauma

  "We know that childhood histories of abuse are much more common than once reported. And there is growing research to show that a history of trauma can impact an individual's physical and mental health."

- Examples of screening questions:

  "Have you experienced any difficult life events (abuse, violence, trauma) that you think might be related to some of the things you are struggling with now?"

  "Did you experience any trauma or violence in your childhood or as an adult that you think would be important for me to know about, or that you think might be related to some of the things you are struggling with now?"

- Develop a **comfort** asking and talking about trauma

Adapted from the *Handbook on Sensitive Practice for Health Care Practitioners: Lessons from adult survivors of childhood sexual abuse* (p.62, 2009)

Responding

- **Empathy (normalize and validate)**
  "I appreciate that you shared this with me today."
  "Substance use/anger/dissociating is a common way of coping."
- **Reflective listening**
- **Provide information**
  "We know that interpersonal trauma can have a significant impact on health and wellbeing."
- **Identify clients' needs and explore implications for care**

- **Keep in mind:**
  - Survivors of trauma often feel out of control, fear they are "damaged to the core and beyond redemption". B. vander Kolk

Responding to spontaneous disclosure

- **Acknowledge what you heard by:**
  - Providing emotional support
  - Listen, acknowledge the impact – “I feel sad to hear that you have been through this experience”
  - Normalizing the survivor’s reactions, responses and ways of coping “Your sense that no one is trustworthy makes a lot of sense – you have kept yourself safe by being wary of others who could also hurt you”
  - Being authentic, empathic and caring
- Possible Responses:
  - “I can imagine that you have a lot of different feelings about his experience”
  - “This should never have happened to you”
  - “No one deserves to be treated that way”

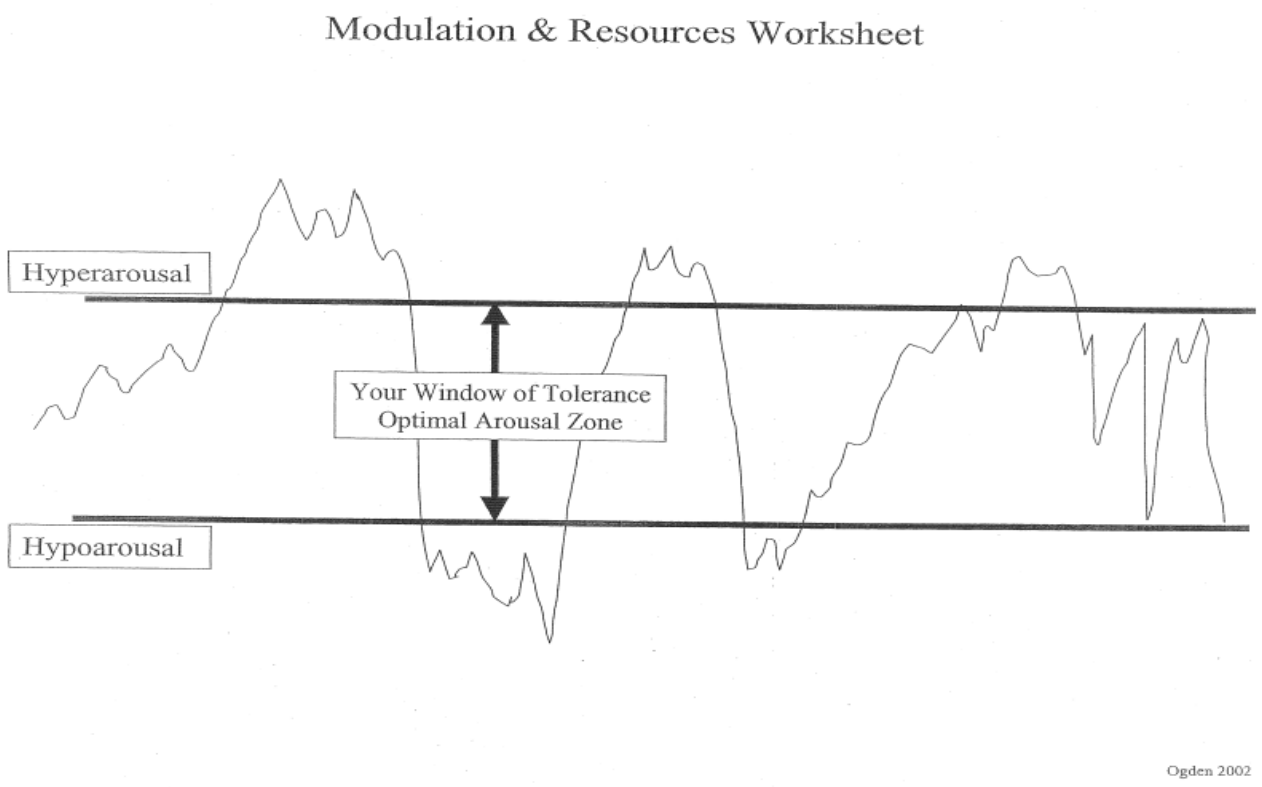
“The essence of trauma is that it is overwhelming, unbelievable, and unbearable. Each patient demands that we suspend our sense of what is normal and accept that we are dealing with a dual reality: the reality of a relatively secure and predictable present that lives side by side with a ruinous, ever-present past.”
— Bessel A. van der Kolk

Tracking and regulating affect

- Patients often have difficulty modulating their affect
  - Pulled to the past or fearful of future harm
- Pay attention to signs of a trauma response
  - If needed, pause and help the individual to connect to the present moment
- Must address this imbalance and reestablish the individuals' physical sense of safety and help move them into window of tolerance

Trauma response

- Trauma disrupts the body's natural equilibrium
- Freezes you in a state of hyperarousal and/or hypoarousal and fear



What to do if a person is triggered

Listen (don't try to fix the problem)

Be a **supportive presence**

Emotions naturally subside – a **wave-like quality** – will slowly dissipate especially if acknowledged and validated

Pause and allow a moment or two for the wave to pass

Hold the space by sitting and witnessing their feelings

Simply be a presence

Verbal response could be:

"That must have been very painful. Of course thinking about it brings up emotions".

Grounding may be necessary if emotions are not subsiding…

Grounding

- Goal:
  - Detaching from emotional pain
  - Get in touch with the present moment
  - Direct attention to something else
- Grounding strategies can be helpful when person may be feeling “pulled to the past”
- Make suggestions: “Can we try something together?”
  - Notice that you’re holding your coffee cup, do you notice the temperature? (physical)
  - Bring your attention to your feet, notice they are on the floor, dig your heels in a bit and remind yourself “I’m here” (physical)
  - Do you notice any particular colors in this space? Turning your head and shifting your gaze can help – describe what you see (mental)

Najavits, Lisa M., *Seeking Safety: A Treatment Manual for PTSD and Substance Use*, 2002

Avoid

- Asking for a detailed account of their trauma history
- Touch
- Making assumptions
  - e.g., “I am sure life is much better without your partner controlling you,” “You must really hate your father for what he did.”
- Minimizing someone’s experience
  - e.g., “At least you don’t _____,” “If you look on the bright side, _____”
- When recognizing resiliency, be sure to also acknowledge the struggle
  - e.g. “Given all these struggles, what has allowed you to cope?”

Re-traumatization

- Healthcare can be re-traumatizing, particularly for those with interpersonal trauma
  - Intimate, power differential
- Requires us to work in ways that accept where the person is at

Research suggests:

It is not the disclosure that leads to harm, rather it is the negative reaction to the disclosure

(Becker-Blease & Freyd, 2006)

Specialized trauma treatment (1)

PTSD treatment

- Psychotherapy (Cochrane 2013):
  - Trauma-focused CBT (TF-CBT) is most effective (CBT is as well)
  - EMDR (eye movement desensitization and re-processing)
  - Group TF-CBT effective but higher drop-out rates
  - Somatic Experiencing: Focus = bodily sensations, rather than thoughts and memories, person concentrates on what's happening in their body, from there, the natural survival instincts take over, safely releasing this pent-up energy through shaking, crying, and other forms of physical release

- Medications (Cochrane 2006) (Jeffreys 2012- review):
  - SSRIs and venlafaxine: first-line
  - Prazosin: Good evidence for nightmares
  - Benzos: Poor outcomes
  - Anti-psychotics: Limited evidence, significant side effects

Specialized trauma treatment (2)

Seeking Safety Treatment Group (Najavits) (PTSD and substance use disorders)

- Review articles (Najavits 2013) - all treatment interventions for PTSD and substance use disorders
  - Most had positive outcomes, particularly for PTSD
  - Best evidence for combined, integrated treatment
  - Consistently best outcomes for substance use disorders

DBT

- Effective for patients with borderline personality disorders
- Recognizes that most with BPD- raised in “profoundly invalidating environments”- lack skills to cope with distress - approach includes acceptance of person, and encouragement to make change
- 4 major skill building areas:
  - Distress tolerance
  - Emotion regulation
  - Mindfulness
  - Interpersonal effectiveness: Getting needs met without destroying relationships/self-respect

Resources

Books and articles

- Trauma and Recovery, Dr. Judith Herman
- Duarte Giles, M., Nelson, A.L., Shizgal, F., Stern, E-M., Fourt, A., Woods, P., Langmuir, J., & Classen, C.C. (2007). A Multi-Modal Treatment Program for Childhood Trauma Recovery: Women Recovering from Abuse Program (WRAP). Journal of Trauma & Dissociation, 8(4), 7-24.
- Pearlman, L.C., & Courtois, C.A. (2005). Clinical Applications of the Attachment Framework: Relational Treatment of Complex Trauma. Journal of Traumatic Stress, 18(5), 449-459
- "Treating the Trauma Survivor: an essential guide to trauma-informed care" by Anne Fourt, Carrie Clark, Maithili Shetty, Catherine C. Classen
- "Seeking Safety: A treatment manual for PTSD and Substance Use" by Lisa Najavits
- "It's Not You, It's What Happened to You: Complex trauma and treatment" by Christine A. Coutois
- "Trauma Matters: guidelines for trauma-informed practices in women's substance use services" March 2013 by The Jean Tweed Centre, Toronto, Ontario

Websites

- Helpguide.org: http://www.helpguide.org/articles/ptsd-trauma/emotional-and-psychological-trauma.htm
- Mental Health.ca: http://www.ementalhealth.ca/
- CAMH.ca: http://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/Trama/Pages/default.aspx
- The Trauma Toolkit (trauma-informed care): http://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf

References

- 1993 National Prevalence
- Survey Results from the Ontario Health Supplement.
- [JAMA, 1997] H L MacMillan, et al
- MacMillan, H L, J E Fleming, N Trocmé, M H Boyle, M Wong, Y A Racine, W R Beardslee, and D R Offord. “Prevalence of Child Physical and Sexual Abuse in the Community. Results from the Ontario Health Supplement.” *JAMA: The Journal of the American Medical Association* 278, no. 2 (July 9, 1997): 131–135.
- Dube, Shanta R, Robert F Anda, Vincent J Felitti, Valerie J Edwards, and Janet B Croft. “Adverse Childhood Experiences and Personal Alcohol Abuse as an Adult.” *Addictive Behaviors* 27, no. 5 (September 2002): 713–725. doi:10.1016/S0306-4603(01)00204-0
- Cochrane Reviews
- Centre for Disease Control and Prevention http://www.cdc.gov/violenceprevention/acestudy
- http://www.samhsa.gov/children/social_media_apr2011.asp
- Bisson, Jonathan I, Neil P Roberts, Martin Andrew, Rosalind Cooper, and Catrin Lewis. “Psychological Therapies for Chronic Post-Traumatic Stress Disorder (PTSD) in Adults.” *The Cochrane Database of Systematic Reviews* 12 (2013): CD003388. doi:10.1002/14651858.CD003388.pub4.
- Gillies, Donna, Fiona Taylor, Carl Gray, Louise O’Brien, and Natalie D’Abrew. “Psychological Therapies for the Treatment of Post-Traumatic Stress Disorder in Children and Adolescents.” *The Cochrane Database of Systematic Reviews* 12 (2012): CD006726. doi:10.1002/14651858.CD006726.pub2.
- Stein, D J, J C Ipser, and S Seedat. “Pharmacotherapy for Post Traumatic Stress Disorder (PTSD).” *The Cochrane Database of Systematic Reviews*, no. 1 (2006): CD002795. doi:10.1002/14651858.CD002795.pub2.
- Jean Tweed: http://www.jeantweed.com/LinkClick.aspx?fileticket=PyPh_4G36vk%3d&tabid=107&mid=514
- Brown, C., Petite, K., Haanstra, A., Stewart, S. (2009) The Pervasiveness of Trauma Among Canadian Women in
- Treatment for Alcohol Use, Dalhousie University. Available online at
- Elliott, D.E, Bjelajac, P., Markoff, L.S., Fallot, R.D., and Reed, B.G. (2005). Trauma-Informed Or Trauma-Denied:Principles and Implementation of Trauma-Informed Services for Women. Journal of Community Psychology,Vol. 33, No. 4, 461–477
- Toolkit: http://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf