

Trauma-informed Services: Implications for Healthcare Providers and Systems

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Lynne Stevens Memorial Lecture

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First, take a moment...

What Do We Mean by “Trauma”?

Individual Trauma: Trauma is the **unique individual experience of an event or enduring condition**, in which:

- The individual is exposed to actual or threatened death, serious injury or sexual (and/or psychological) violation (by directly experiencing, witnessing or learning about a traumatic event (to a loved one) or has first hand repeated exposure)
- The individual’s coping capacity and/or ability to integrate his or her emotional experience is overwhelmed causing significant distress

Collective Trauma

- Cultural, historical, insidious and political/economic trauma that impacts individuals and communities across generations

Interpersonal Trauma: Intimate and social betrayal; Cumulative burden; Ongoing risk

What Do We Mean by Trauma-Informed and Why Does it Matter?

- Trauma is pervasive
- Trauma has significant health and mental health effects & is a leading cause of morbidity and mortality across generations
- Trauma can affect survivors' access to and experiences of health care.
- Without an understanding of trauma services can be retraumatizing.
- As health care providers, we are also affected by trauma and need to be supported in addressing our own feelings if we are to remain open to the experiences of our patients

What Do We Mean by Trauma-Informed and Why Does it Matter?

How we respond and the environments we create make a difference.

- When we are able to respond in trauma-sensitive, person-centered ways patients feel safer disclosing, are more likely to access services, and are more likely to find treatment helpful.
- Inquiring about abuse, making it safe for survivors to talk about their experiences, responding compassionately, tailoring services to individual needs and offering appropriate referrals are also critical.
- Creating organizational culture that supports compassionate, trauma-informed care is essential

Why Address Trauma in Health Care Settings?

Trauma is Pervasive

National Co-morbidity Study: N=5,877

- Lifetime trauma exposure
 - >60% men; >50% women

ACE Study: N = 17,377

- 10 Categories of childhood trauma
 - 63% at least one; 25% two or more; 20% >3

Trauma in Urban Primary Care: N=509

- 16 categories of trauma
 - 79%; 65% exposed to more than one category; low recognition

Trauma has Significant Health & Mental Health Consequences

- **GBV** increases risk for mental health and substance abuse conditions (89% MH condition if experience 3-4 types)
- **Women** are 2x as likely to develop PTSD & depression after trauma exposure; 4x as likely to develop PTSD symptoms in the context of IPV
- **IPV/trauma survivors** have higher rates of asthma, DM, IBS, STDs, HIV, autoimmune disorders, stress sx, injuries, chronic pain pregnancy complications & sleep disturbances
- **Adverse childhood experiences** increase risk for health, MH & substance abuse problems as adults

Abuse and Violence

Play a key role in the development and exacerbation of health, mental health & substance abuse conditions

Adverse Childhood Experiences Study

N=9,508 & 17,337 Adults in HMO

Physical, Sexual, Psychological abuse & neglect, Witness violence toward mother, Household members with substance abuse, Suicide Attempts or Incarceration, Loss of parent (separation/divorce)

- **Dose response between # of experiences &:**
 - Alcoholism, Drug abuse, Depression, Smoking, IPV
 - Poor health, 50 or more sexual partners, unintended pregnancy, obesity and physical inactivity
 - CHD, CA, liver disease, skeletal fractures, COPD
 - Psychiatric hospitalization, suicide attempts, hallucinations
 - Any ACE increased suicide risk by 2-5X

At the same time.....

**Experiencing a Mental Health
or Substance Abuse Condition
Puts Women at Greater Risk
for Being Abused**

High Risk for Abuse Among Women Receiving Mental Health Services

<u>Type of Abuse</u>	<u>OP Prevalence</u>	<u>MI</u>
▪ Adult physical	▪ 42%-64%	87%
▪ Adult sexual	▪ 21%-41%	76%
▪ Child physical	▪ 35%-59%	87%
▪ Child sexual	▪ 42%-45%	65%

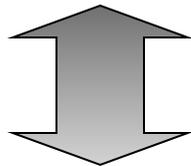
Women living with chronic mental illness experience higher rates of abuse
Women abused in childhood experience higher rates of psychiatric symptoms, homelessness and sexual assault as adults
Women in inpatient settings experience high rates of DV

Trauma & DV Increase Women's Risk for Substance Abuse

- **Higher rates of substance abuse** among women who have been victimized
- **High rates of victimization** among women in substance abuse treatment
- **Self-medication** common; may be symptom specific
- May be **coerced into using** or dealing
- **Using increases risk for coercion**

Why is this? Risk vs. Vulnerability

- **Batterers use MH & substance abuse issues to control their partners**



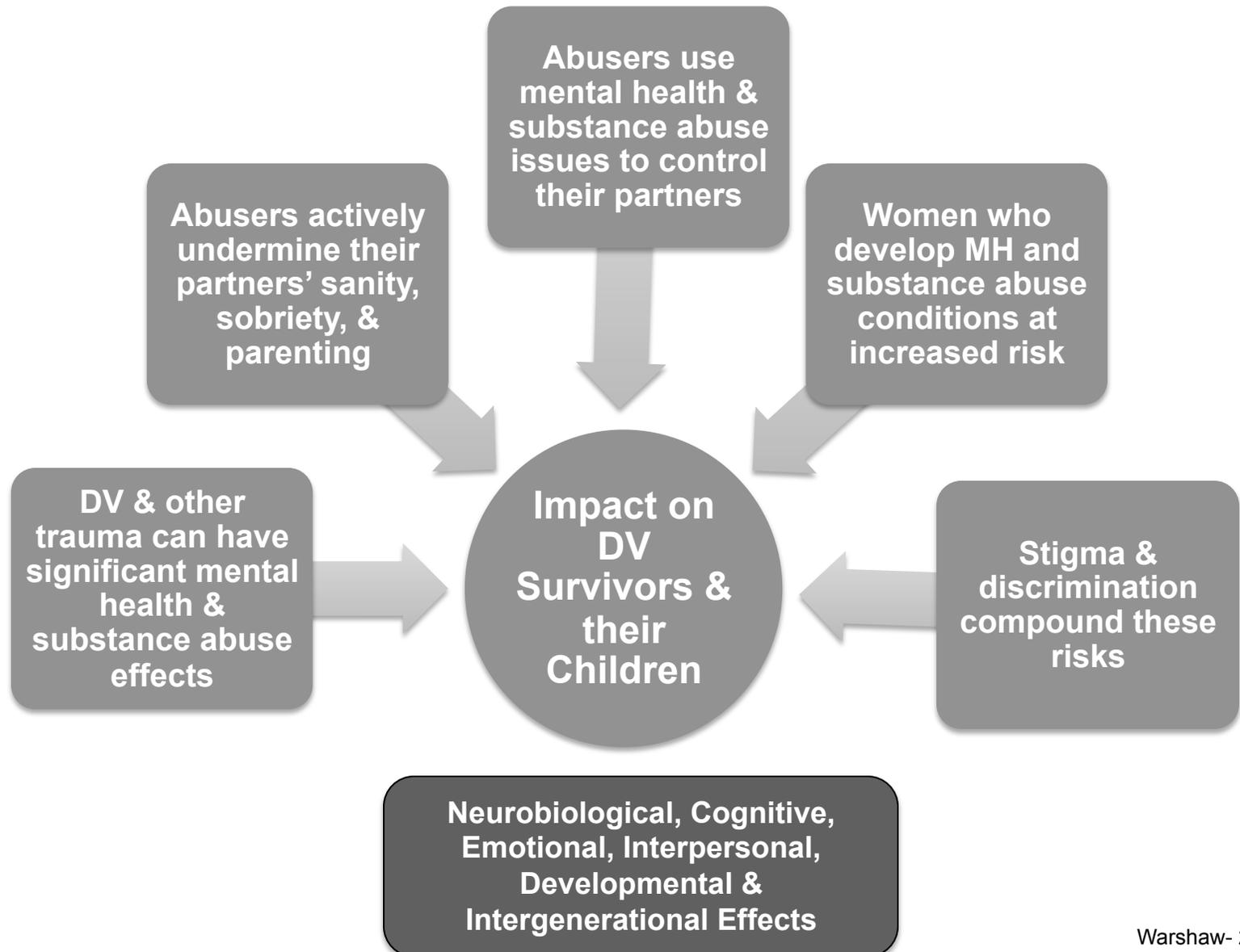
- **Stigma, poverty, discrimination & institutionalization compound these risks**

- Control of meds
- Coerced overdose
- Control of supply; Coerced use; Coerced illegal activities
- Control of treatment
- Undermining sanity, credibility, parenting & recovery
- “She was out of control”

WHY DOES THIS WORK?

- Reports of abuse attributed to delusions
- Symptoms of trauma misdiagnosed as MI
- Assumptions that having a MI precludes good parenting
- Internalized stigma

DV/SA, Trauma, Substance Abuse & Mental Health: Complex Interactions



Trauma & DV

Reduce Access to Services

- **Trauma can affect access to services**
 - Avoidance of trauma triggers
 - Reluctance to reach out when trust has been betrayed
 - Retraumatization in clinical settings; misperception of trauma responses and coping strategies
- **Need for DV- and trauma-informed services**
 - Without a trauma framework, services can be retraumatizing
 - Without a DV framework, services can be unsafe



Trauma Theory

**Bridging Clinical and Advocacy
Perspectives**

How is a Trauma Framework Helpful?

- **Normalizes human responses to trauma**
- **Shifts our conceptualization of symptoms**
 - Injury model; Symptoms as survival strategies
- **Offers a more holistic approach**
 - Multiple domains/multidimensional approaches to healing
- **Attends to impact on providers & organizations**
- **Incorporates social justice/human rights perspective**

Emergence of Trauma Theory:

Reframing Symptoms from a Trauma Perspective

- **1980's PTSD**
 - Injury model
- **1990's Complex Trauma**
 - Developmental lens; multidimensional approach
 - Attachment & parenting support
 - Borderline reframe
- **2000's Neuroscience Research**
 - Circuits & pathways
 - Gene X environment interactions, neuroplasticity



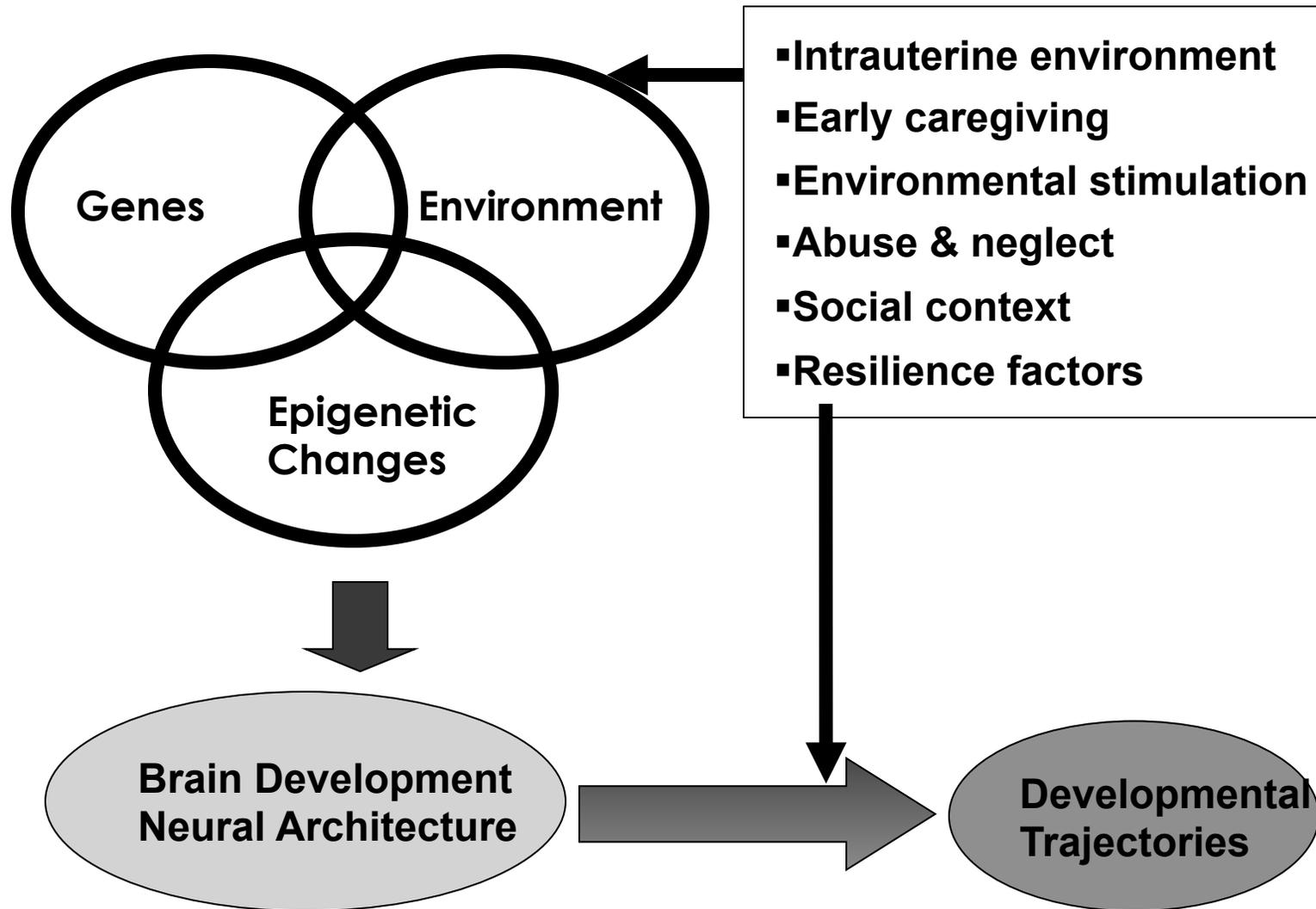
Trauma, Attachment & Brain Development

Understanding the Traumatic Effects of Abuse

Why a Developmental Framework Is Important

- **Our brains grow in relation to our experience**
 - Experience stimulates neural circuitry. Those consistently stimulated are strengthened
- **The nature and quality of those experiences help to shape our development**
 - Fine tunes brain architecture
- **Brain development involves complex interactions between genes & environment over time**

Epigenetics: Trauma, Development & Nature-Nurture Interplay



Early Experience & Brain Development: Mirror Neurons, Empathy & Attunement

- **We develop neural connections through attunement**
- **Empathy & attunement are hardwired**
- **We learn by watching, imitating & matching**
 - Mirror neurons, begin working at birth.
 - They are involved when a child observes an action and then practices performing it.
- **We learn by attuning to others' responses to us**
 - Sense of being seen and known; sense of self
- **Learning brain vs. survival brain**

Banissy & Ward 2007; Hunter et. al. 2013

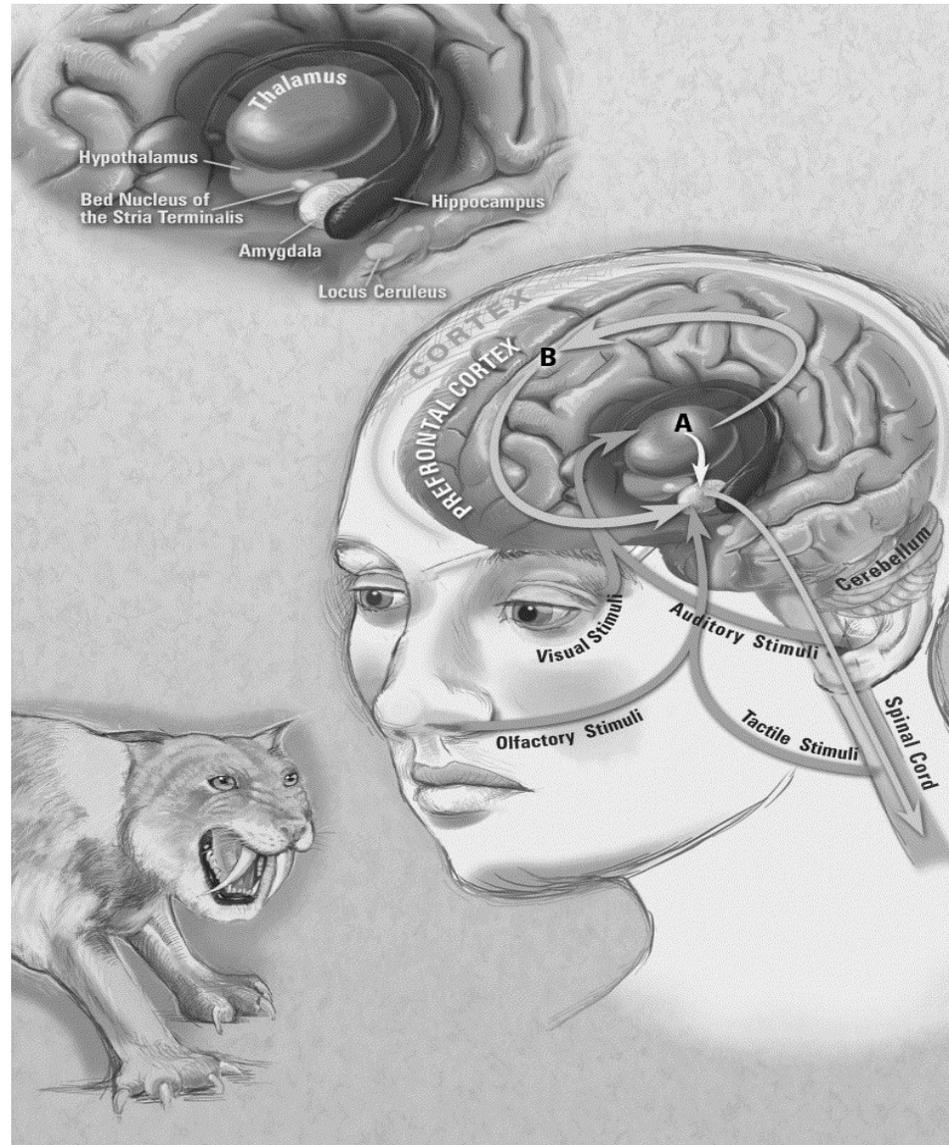
Understanding Complex Trauma: Importance of Early Attachment Relationships

- **Emotional bond with caregivers: model for future relationships & trust**
- **Important source of resilience & ability to manage stress**
- **Template for developing self-regulating, integrative & empathic capacities**
- **Active throughout life**

Stress & Trauma in the Context of Attachment

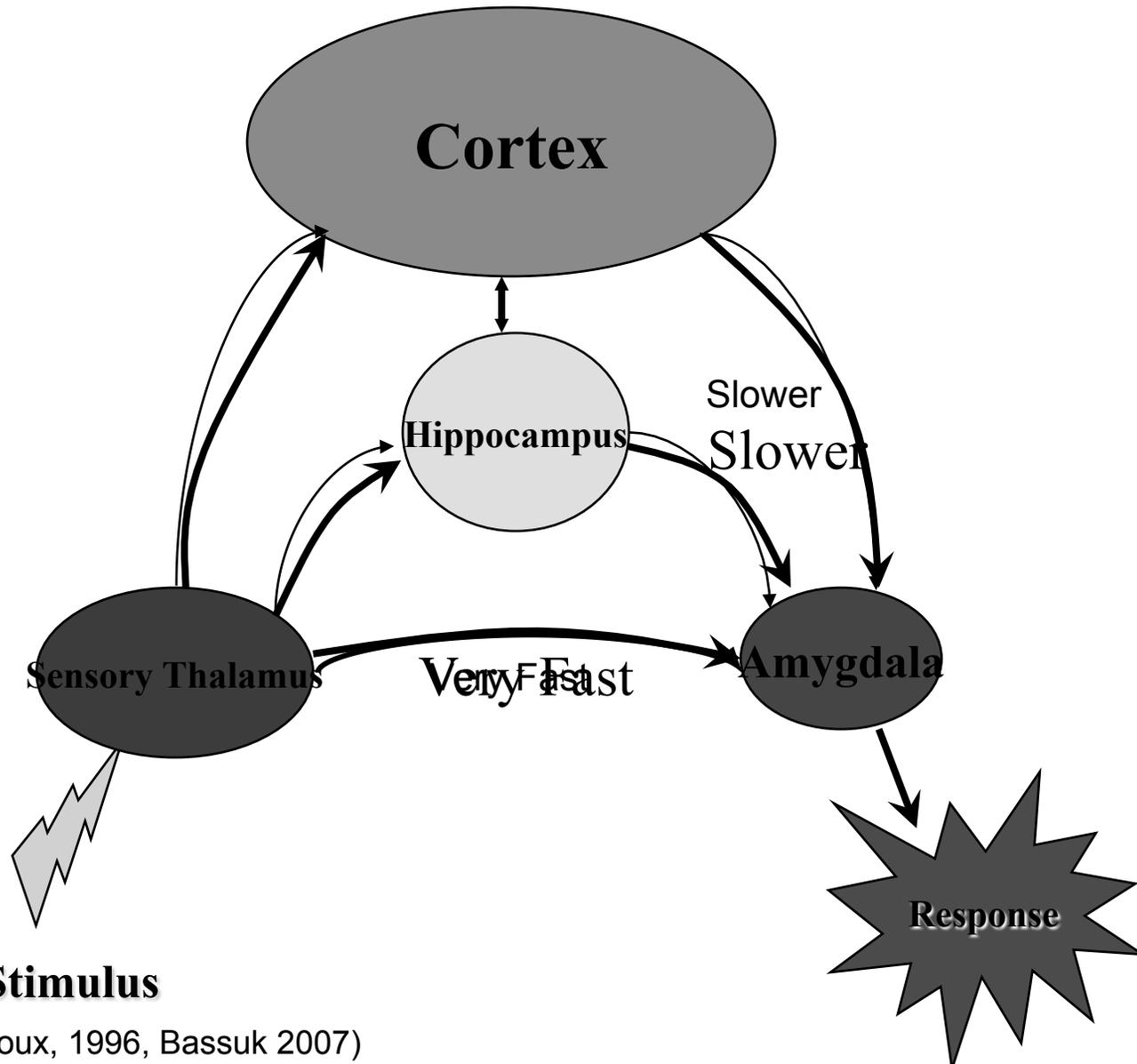
- **Positive stress**
 - Entry to school or child care, managing frustration, routine medical care, riding a bike
- **Tolerable stress**
 - Adverse experiences that occur for brief periods, such as a frightening accident
- **Toxic or Traumatic stress**
 - Stressful events that are chronic & uncontrollable; unrelieved activation of body's stress response system in absence of protective adult support.
- **Complex Trauma**

Normal Stress Response

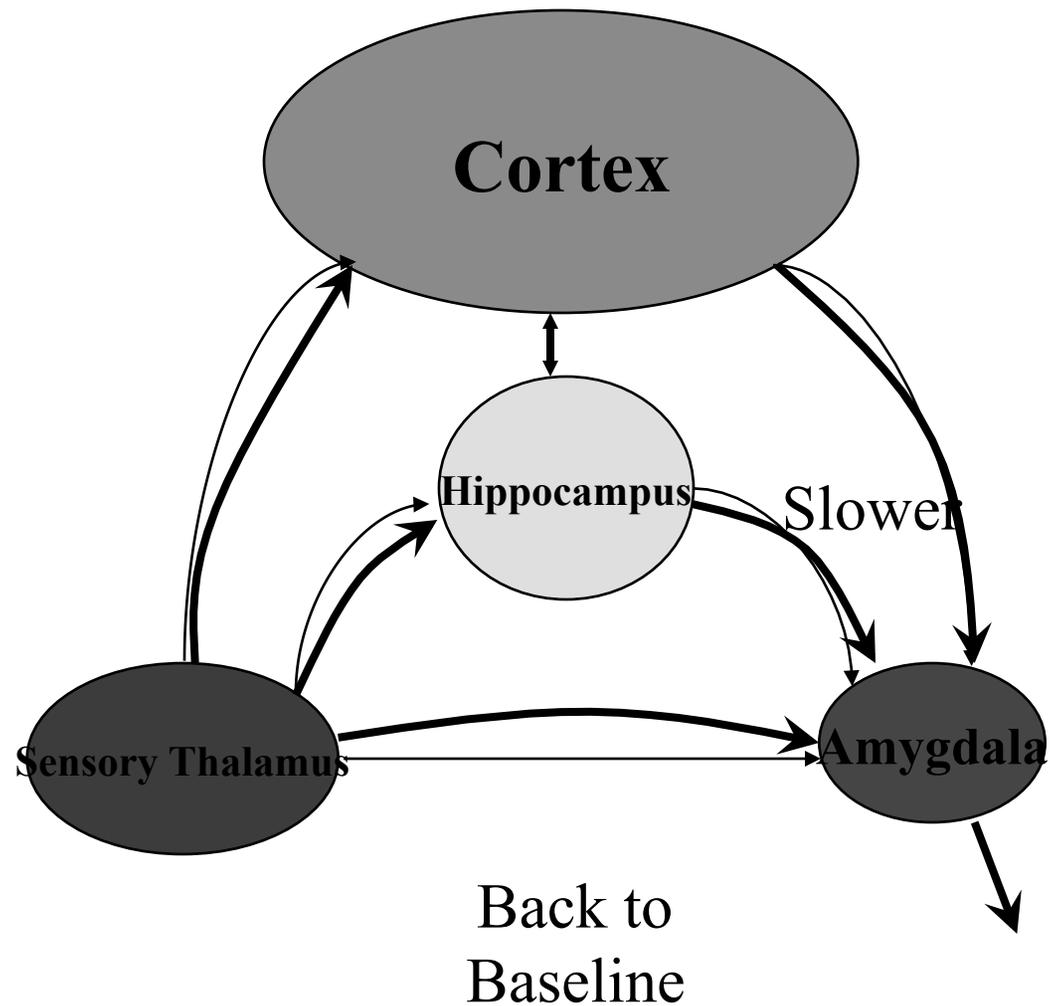


Body's response to a threat or perceived threat,
Time Magazine 6.10.02, Am J. Med. 2006.

Normal Stress Response

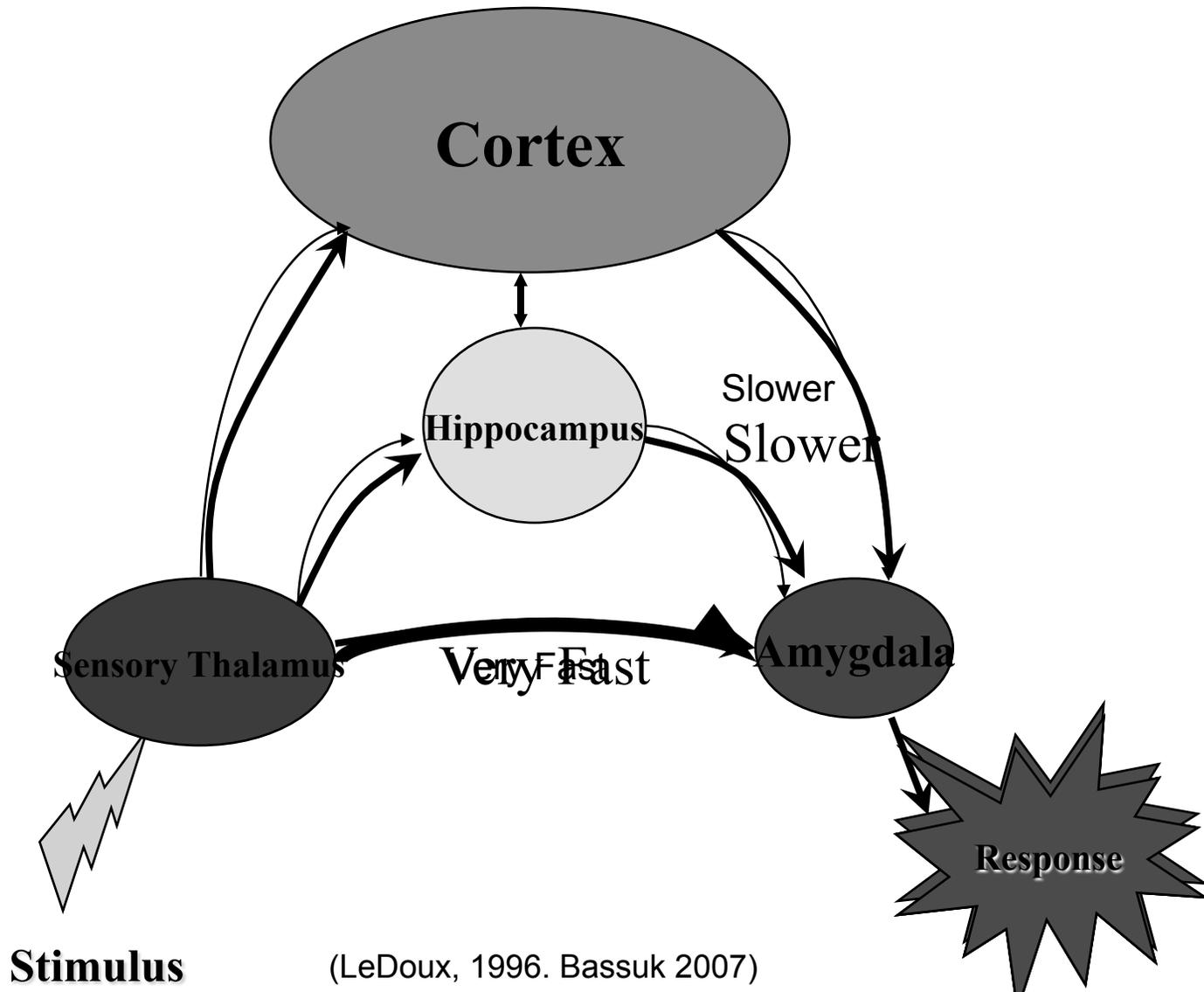


Normal Stress Response



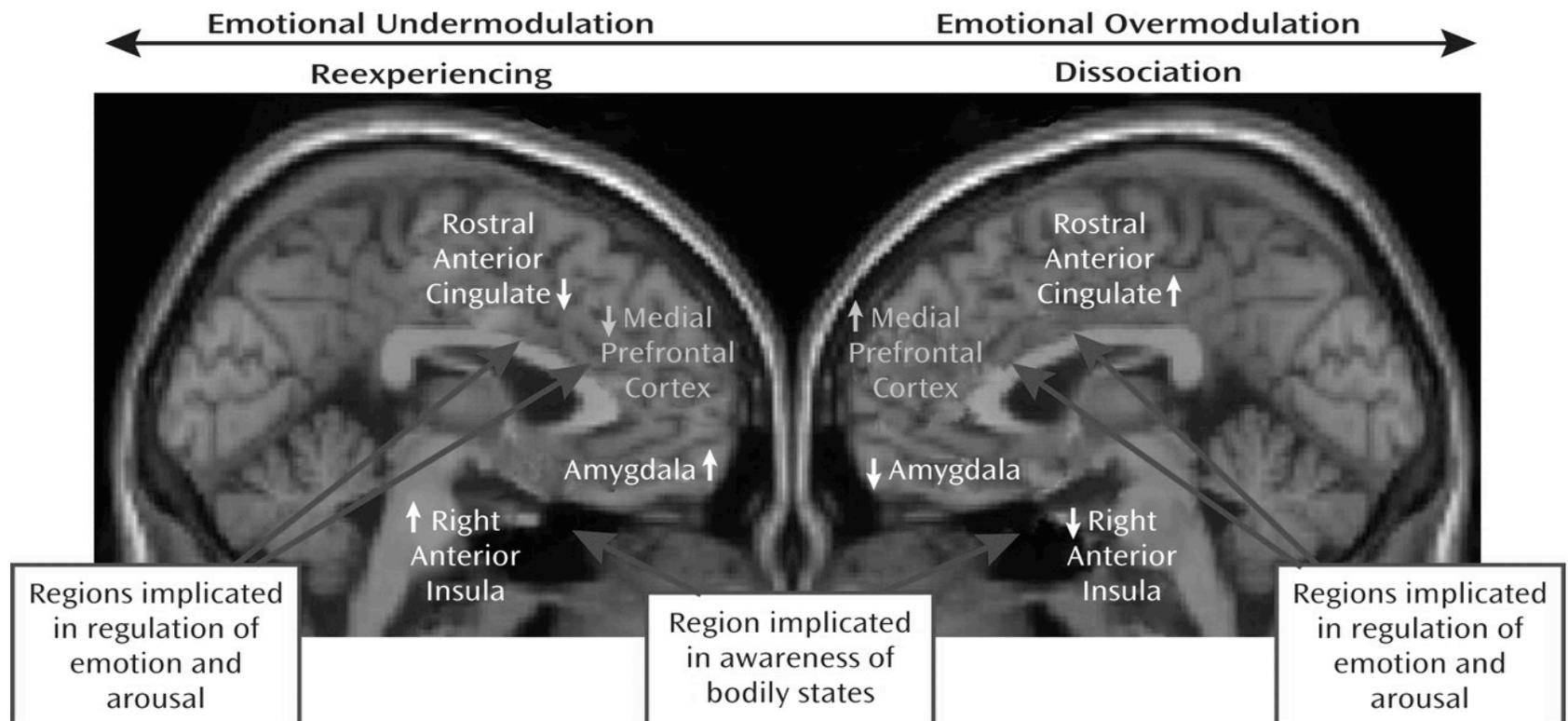
Traumatic Stress Response

Sensitized Nervous System: Under-modulation of Fear Pathways



Emotion Modulation in PTSD:

Clinical & Neurobiological Evidence for a
Dissociative Subtype



Traumatic Stress Response Sensitized Nervous System

- Chronic hyperarousal and threat perception
- Sustained increase in stress hormones; Increased vulnerability to stress-related illness
- Alterations of gene expression, neurochemistry and fear pathways; memory and learning affected
- **PTSD:** Intrusive recollections, avoidance and numbing, hypervigilance and arousal, alterations in mood and cognition, dissociation
- **Complex Trauma:** Affect dysregulation, negative self-concept, interpersonal difficulties
- Can build compensatory pathways

Complex Trauma: How this can affect us as adults

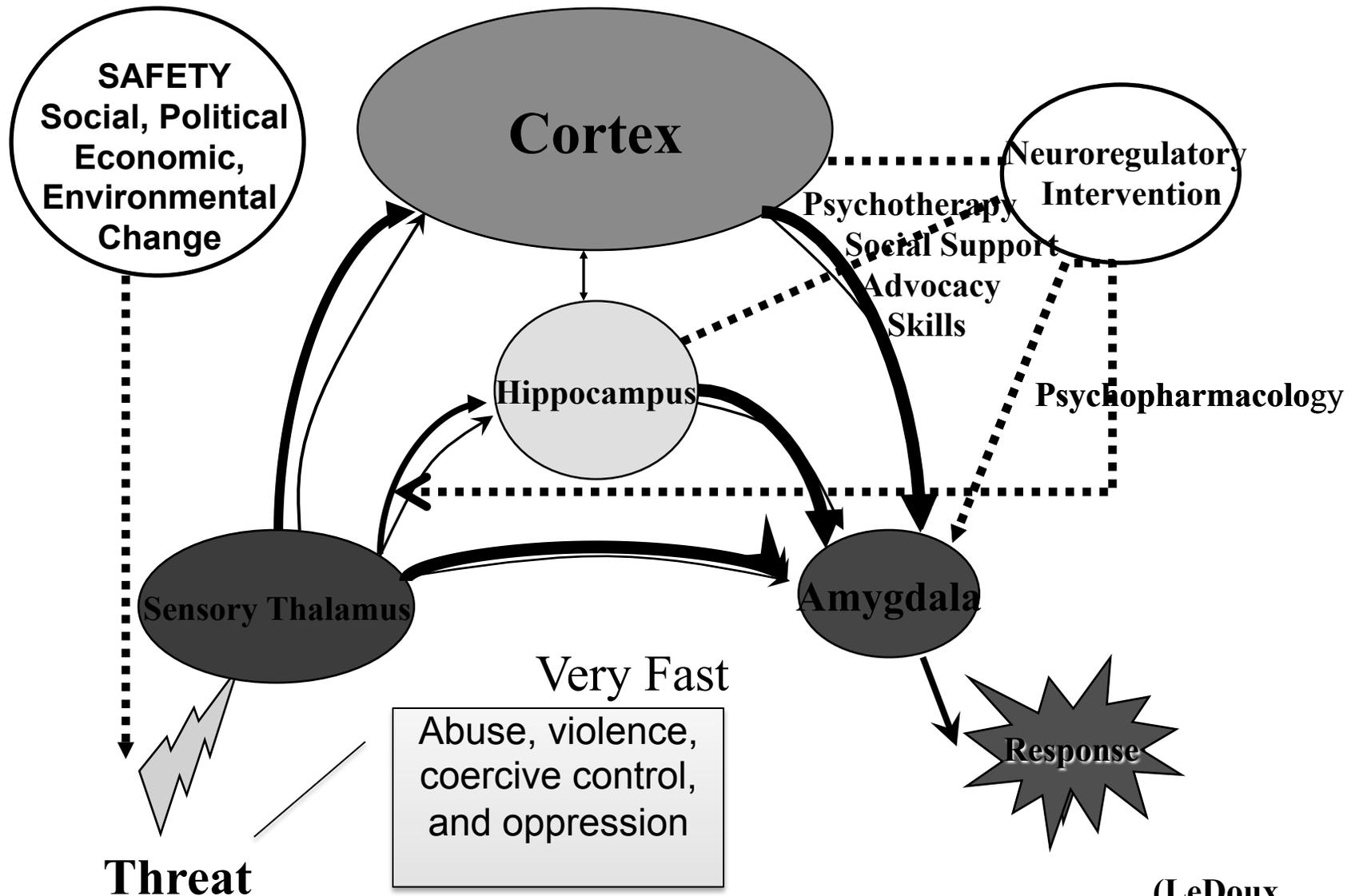
- **Trusting other people**
 - Harder to reach out for or respond to help
- **Trusting oneself**
 - Solve problems, exercise judgment
 - Take initiative, thoughtfully plan
- **Impact on**
 - Emotional awareness, self-reflection, social emotional processing, beliefs and meaning
- **Capacity to manage internal states** in ways that do not create other difficulties
- **Social support and other resilience factors** may counter these effects; quality of interactions is key

Resilience & Protective Factors

- **Resilience:** Capacity for successful adaptation despite challenging or threatening circumstances

- **Protective factors:** Promote resilience in those at risk. These include:
 - Response of caregivers and other caring adults
 - Secure attachment can be most important source of resilience & ability to manage stress
 - Social support, social fabric, community, spirituality
 - Individual factors such as capacities and talents
 - Ability to positively engage others
 - Access to social and economic resources

How Interventions Help



**How does knowing this
help?**

**And, how does it help us to
become trauma-informed?**

How does this help us as institutions?

What do we mean by DV & trauma-informed services and organizations?

Creating DV- and Trauma-Informed Services and Organizations

- **Recognize pervasiveness & impact of trauma:**
 - Incorporate understanding of trauma into every aspect of services & organization
- **Reduce retraumatization:**
 - Counteract experience of abuse: Dignity, respect, safety; Attend to environment; prepare for trauma triggers
- **Facilitate healing, safety & well-being:**
 - Mitigate & transform effects of abuse: Quality of interactions; Attention to safety & coercive control; Range of strength-based, culturally relevant, DV/TI & TS services & treatment options
- **Attend to impact on providers**
 - Reflective supervision; Nurture empathy & self-awareness
- **Address social conditions that perpetuate trauma**

Attend to Trauma & Its Effects

- **Impact of stress/trauma on survivors**
 - Responses as adaptations; Trauma themes; Neurobiology & development
- **Impact of stress/trauma on providers**
 - Vicarious Trauma; Compassion Fatigue
 - Burnout; Responses to survivors
- **Impact of stress/trauma on organizations**
 - When our organizations are under siege, we can inadvertently create traumatizing experiences or environments for survivors and staff*

Parallel Process

- **Impact of stress & trauma on organizations**



- **Impact on staff who work there**



- **Impact on people accessing services**

Bloom, S. SAGE for Organizations



DV- and Trauma-Informed Services

How Does this Translate into Practice?

Creating Culture- DV- and Trauma-Informed Services & Organizations: Key Domains

TI Practice Domains

- Physical, Sensory & Relational Environment
- Intake and Assessment Process
- Programs & Services
- Community Collaboration & Referral Relationships

TI Organization or System Domains

- Organizational Commitment & Infrastructure
- Staff Training and Supports
- Feedback and Evaluation

Considering the Environments We Create

- **Physical & Sensory Environment**
 - Soothing, welcoming & safe; Culture and gender responsive
- **Relational Environment: Restoring dignity and emotional safety; Countering abuser control**
 - Respectful caring connections; Empowering information about trauma; Focus on strengths & resilience
 - Clarity, consistency, transparency, choice & control
- **Clinical Environment**
 - Examine policies & procedures, adaptation, flexibility
 - Emotional safety planning & accommodation; Prepare for trauma triggers

Relational Environment

When trauma occurs in a relationship, the quality of the relationships we create is key.....

Relational Environment

- **Choice & Control:** Counters abuse of power through shared information, power, choice & control
- **Trustworthiness & Respect:** Counters secrecy and betrayal through transparency, consistency and trustworthiness
 - Being clear about expectations, commitments, parameters of services
 - Maintaining respectful interpersonal boundaries; no Jekyll-Hyde behavior
 - Creating a safe atmosphere to discuss misunderstandings
 - Recognizing that what creates safety may be unique to each person

Intakes & Assessments: What Would A TI Approach Involve?

Emotional safety

- Respond with empathy, validation, & respect
- Share concerns without imposing own point of view

Genuine interest and openness

- Provide space to talk about things that are important or challenging without judgment or shame

Attention to imbalances/issues of power

- Create opportunity to participate in give-and-take relationship without risk of retaliation

Awareness of our own responses

- Ability to tolerate fear and uncertainty

Warshaw et. al. 2009

Trauma-Informed Trauma History: To Ask or Not To Ask?

- **When to Ask:** When you have established rapport and trust, feel comfortable discussing, can provide environment that feels safe, have sufficient time, and have access to referrals
- **Task-Centered Inquiry:** Opportunity for survivor to share information immediately relevant to treatment (touch sensitivity) without having to disclose in context of new provider and absence of rapport.
 - **Initial questions:** Is there anything about your past experiences that makes this exam particularly difficult for you? What can I do to make it easier for you? Are there other things that have happened to you that may be affecting how you are feeling now?
- **Relationship-Centered:** Initiated by survivor after trusting relationship established, leading to enhanced understanding of patient needs, greater expectations for positive and supportive response

2.46

Trauma-Informed Approaches: Attend to Responses & Process of Assessment

- **Ensure rooming alone** time but also choice; Ask when person is fully clothed
- **Establish trust**, rapport, safety, comfort, time, referral sources; Normalize and prepare: sensitivity, patience, shared control
- **Ask open ended questions**/discuss disclosure so person can assess clinician readiness
- **Attend to impact**; be mindful of trauma responses
- **Respond empathically** to disclosures; listen, validate, don't compare
- **Discuss strategies** for dealing with impact

Trauma-Informed Assessment:

Providing Information; Normalizing Experiences

- **Talk with survivors about the effects of DV/SA and other trauma in ways that help to normalize and destigmatize their experiences and offer information, tools, resources & hope.**
 - Common physical and emotional effects of trauma and DV and ways these responses can interfere with accessing safety, processing information or remembering details
 - Ways that trauma can affect our ability to trust and manage feelings and affect the ways we feel about ourselves, other people and the world

Clinical Services: Universal Precautions: Anticipate and Prepare for Potential Trauma Triggers

▪ Medical Procedures

- Pap smear or pelvic exam; L&D, mammograms, breastfeeding, ultrasound gel
- Catheterization, Intubation, IV insertion
- Laryngoscopy/endoscopy/colonoscopy/MRI/CT
- Surgery, anesthesia, recovery room

▪ Chaotic sensory environment; Gender-related concerns

▪ Relational triggers

- Closed room; Having to disrobe, Masked and gowned providers, Being touched, False reassurances, Lying down, lying still

Trauma-Informed Medical Examinations

- **Always ask** for consent. Ensure continued consent at each step.
- **Explain** what will be done, how it will be done, and why it is necessary
- **Ask whether the person would like someone with her/him**
- **Do not assume** that any procedure or examination is routine.
- **Observe body language.** Ask “Are you comfortable with this?” or “Is it OK if I continue with the exam?”.
- **Avoid false reassurance.** Give specific advice on how to relax if needed. Discuss in advance. Write things down
- **If she is triggered,** let her know where she is, she’s in a safe place, encourage to look at you, and focus, calm voice
- **Use similar precautions if examining her children, take breaths**

Thinking About Trauma in the Context of Domestic Violence

Incorporating a DV- and Trauma-Informed Approach

Thinking About Trauma in the Context of DV

- **Recognize that** perpetrators may look psychologically healthier than the partner they've been abusing for years.
- **Be wary of** having abusers provide collateral information; Ask about advance directives
- **Do not focus on** helping women understand why they unconsciously “chose” to be abused.
- **Incorporate questions about** mental health and substance abuse coercion and into safety planning
- **Ask about** suicidality in the context of trauma. Abandonment, resistance and perpetrator threats
- **Ensure** survivor choice and control re: medication
- **Consider** impact of trauma & DV on ability to process information

DV- & Trauma-Informed Response to Mental Health Coercion

- **Remember that** a partner who is abusive may try to find other people to agree that your mental health needs give him/her a right to control or abuse you. This is not so.
- **Even if you have** had many hospitalizations, or used medication for years, you have the same right to safety and dignity as anyone else.
- **It might be helpful to think about** which people in your life agree that you have a right to safety and dignity and who you can call on for support.

Markham 2011

Impact of Abuse: Substance Use in Context

Survivor's assessment of:

- Relationship of substance use to current and past abuse
- Role of abuser in maintaining substance use
- Function substance abuse serves: how it helps
- Impact and other risks: how it hurts
- Attempts to stop, goals, barriers, options and strategies

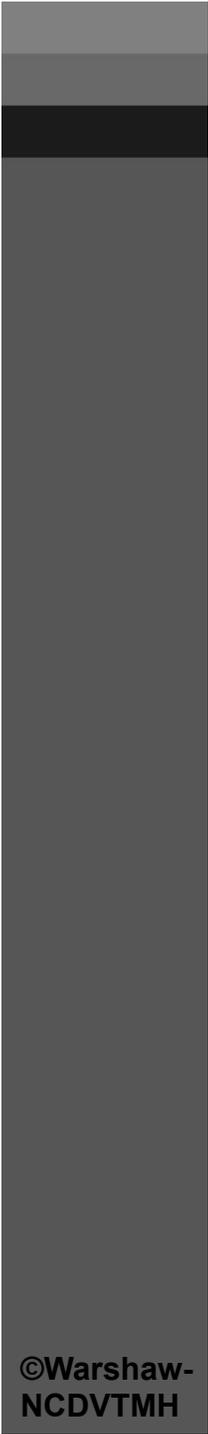
Emotional Safety Planning: Traumatic Effects of Abuse

- **Physical, psychological, and emotional abuse can affect our mental and emotional well-being**
 - You may feel continually afraid, loud noises startle you, you may have nightmares or trouble sleeping, you may have sudden, upsetting memories of abusive incidents that interfere with activities.

- **Being aware of your feelings can help you anticipate situations which are likely to trigger a traumatic response** (i.e. things which make you feel afraid or upset, or cause nightmares) and make decisions about how to handle them.
 - Let's think about what might be helpful. What are some of the things that help you feel calm and centered?

Documenting the Traumatic Effects of DV

- **Document relationship of symptoms to abuse**
- **Discuss potential to subside** when safe
- **Carefully frame** diagnoses and medication
- **Recognize appropriateness of anger**
- **Describe strengths**, coping strategies, & ability to care for and protect children
- **Describe engagement** in treatment; Make sure treatment plan is acceptable and doable
- **Describe observations** about abuser
- **Be alert to abuser** who seems “healthier” than victim



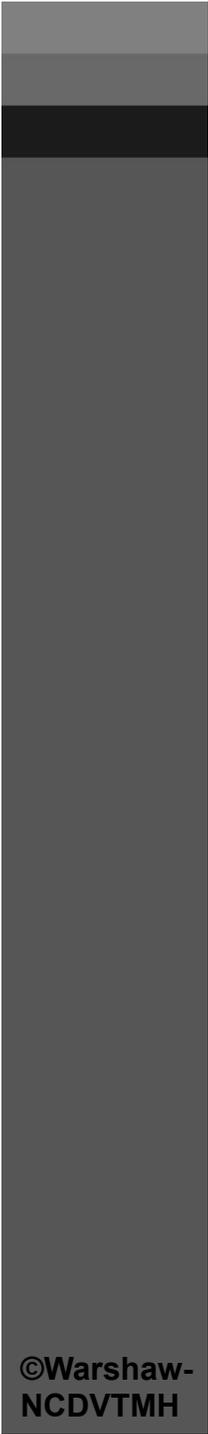
Facilitating Healing and Recovery

Facilitate Healing & Recovery

Healing from interpersonal trauma involves restoring safety, connections, capacities, trust, dignity, respect, meaning & hope and managing dysregulated neurophysiology.

Elements include:

- Physical and emotional safety
- Empowering Information, collaboration & choice
- Building on strengths & resilience
- Enhancing affect regulation and interpersonal skills
- Establishing safe, supportive relationships
- Facilitating reintegration and rebuilding
- Incorporating supportive aspects of culture, community & spirituality and collective approaches



For survivors of ongoing domestic violence, responding to trauma raises an additional set of concerns, particularly when the trauma is unremitting and symptoms also reflect a response to ongoing danger and coercive control.



How does one heal while still under siege?

Trauma Treatment in the Context of DV

- **Symptom-focused vs. Holistic approach**
 - PTSD treatment targets specific symptoms; Complex trauma treatment addresses multiple domains
- **Past abuse vs. Ongoing risk**
 - Most trauma treatment models focus on past abuse; Few are designed for survivors still under siege whether from DV or oppressive conditions
 - Some evidence-based treatments for PTSD can be harmful in context of complex trauma and/or ongoing abuse
 - Women experiencing DV often excluded from clinical trials
- **Treatment should integrate both DV and trauma concerns**

Trauma-Specific Treatment for Survivors of Domestic Violence

- **PTSD Treatment**
 - Robust evidence base: CBT, PE, EMDR
 - Emerging evidence: Mindfulness-based interventions, Mind-Body therapies, Virtual therapies
- **IPV + PTSD Treatment**
 - 9 RCTs but evidence still limited: Modified CBT, yoga-based therapy; often out of the relationship
- **Complex Trauma Treatment**
 - EBPs for less severe complex trauma (Hybrid)
 - Consensus Phase-Based for Complex trauma: EB modalities embedded in relational, developmental matrix; Begin with safety, stability, relationship
 - Combined trauma & substance abuse treatments
- **Culturally Specific Responses to Collective Trauma**

PTSD Treatment in Primary Care: What Are the Possibilities?

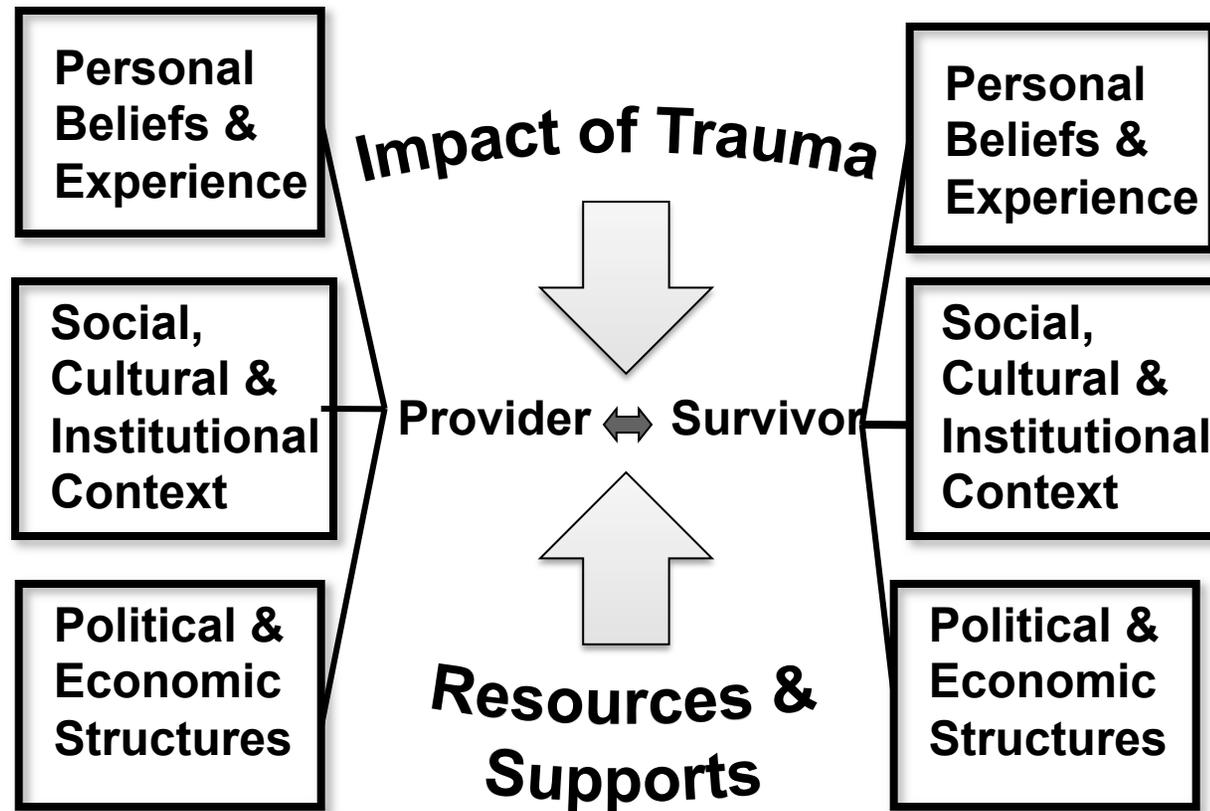
- **Not yet evidence-based**
- **A number of models that could be delivered in primary care settings**
 - Nurse case manager to follow and refer
 - Embedded psychologist or social worker in primary care setting to deliver
 - Web-based and telehealth CBT interventions –ranging from moderate to limited therapist involvement to complete self-help

Possemato 2011

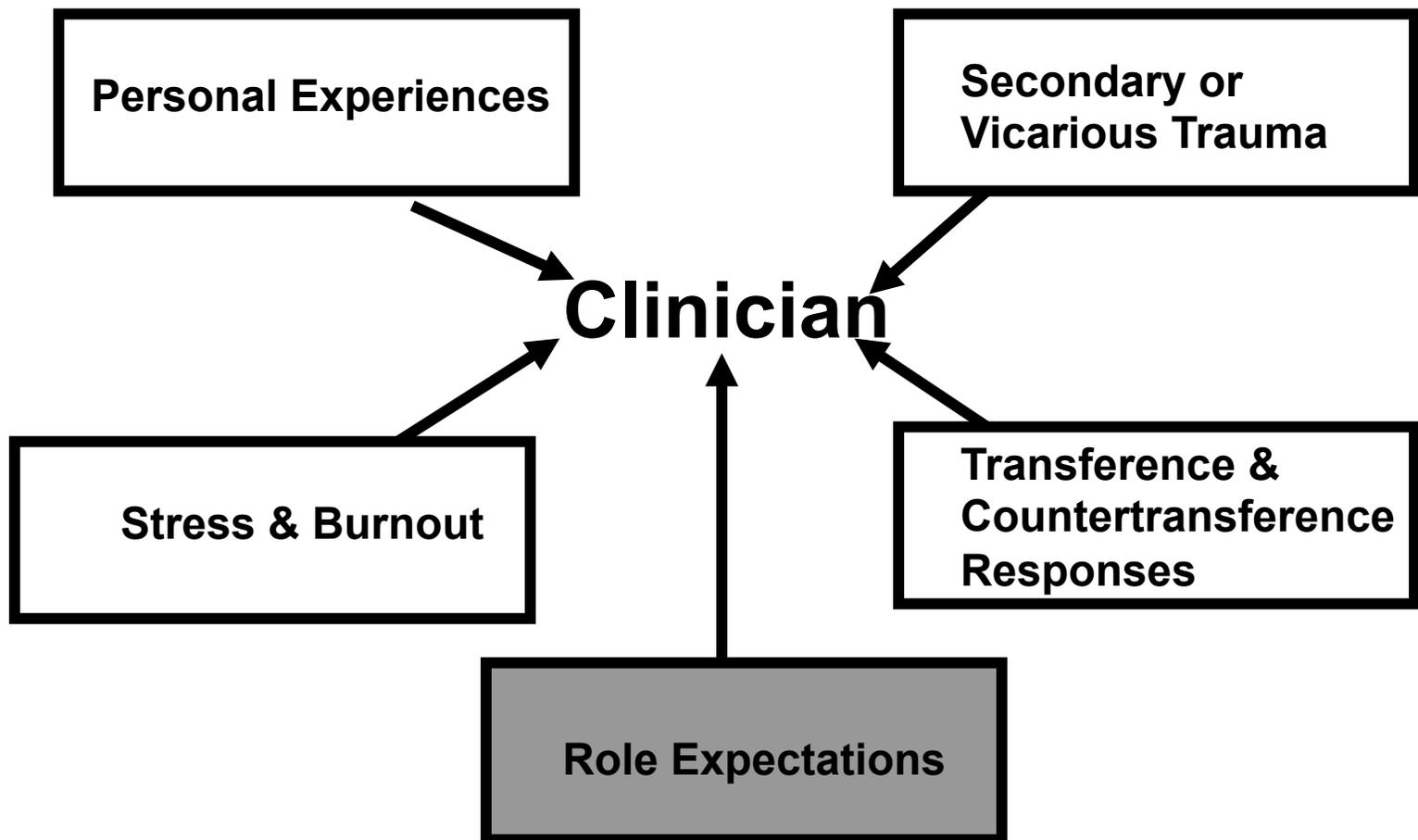
Creating DV- and Trauma-Informed Practices, Training Programs and Institutions

What else is involved?

In a Trauma-Informed Approach, We Are Also Part of the Equation



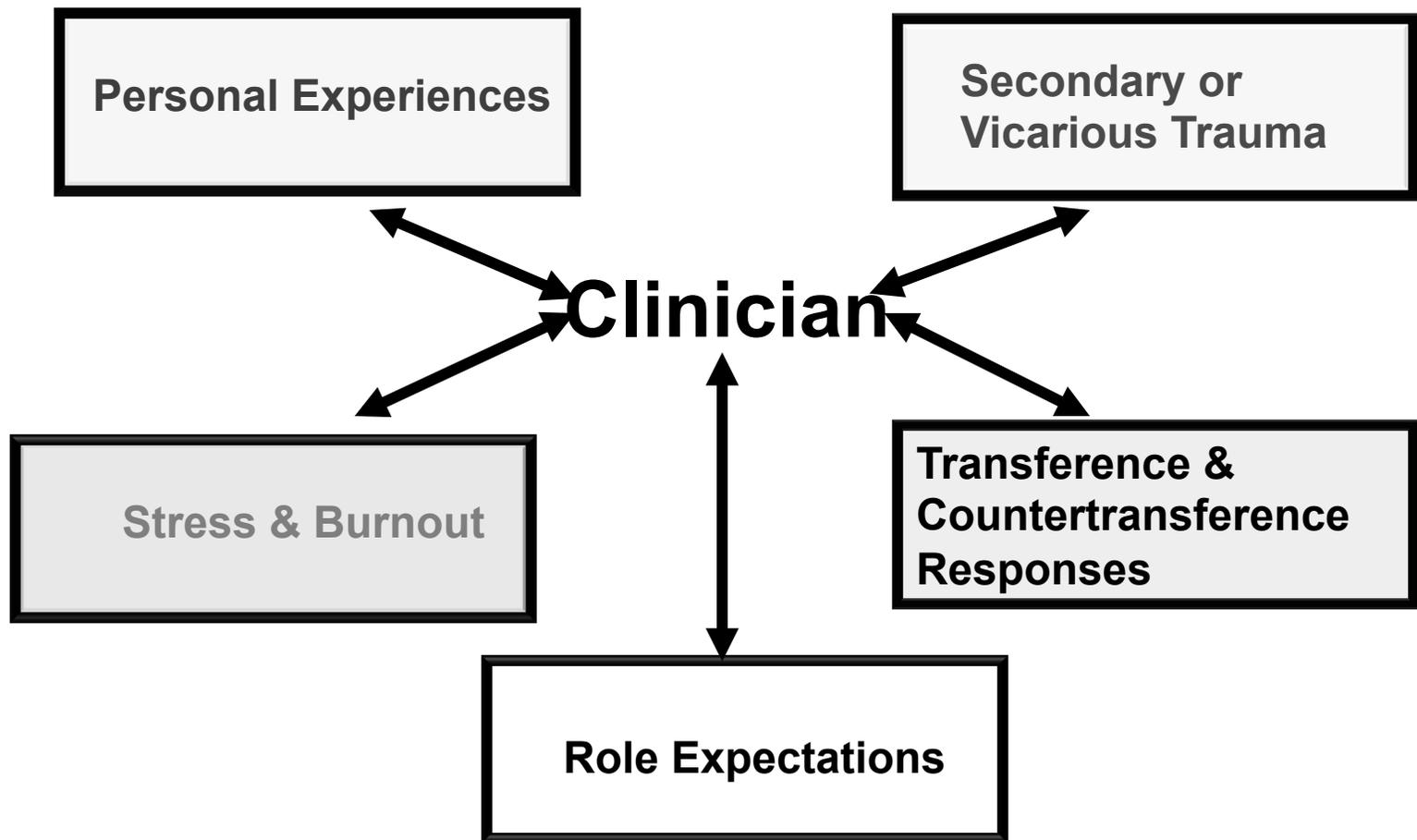
Attending to Our Own Personal Experiences & Responses



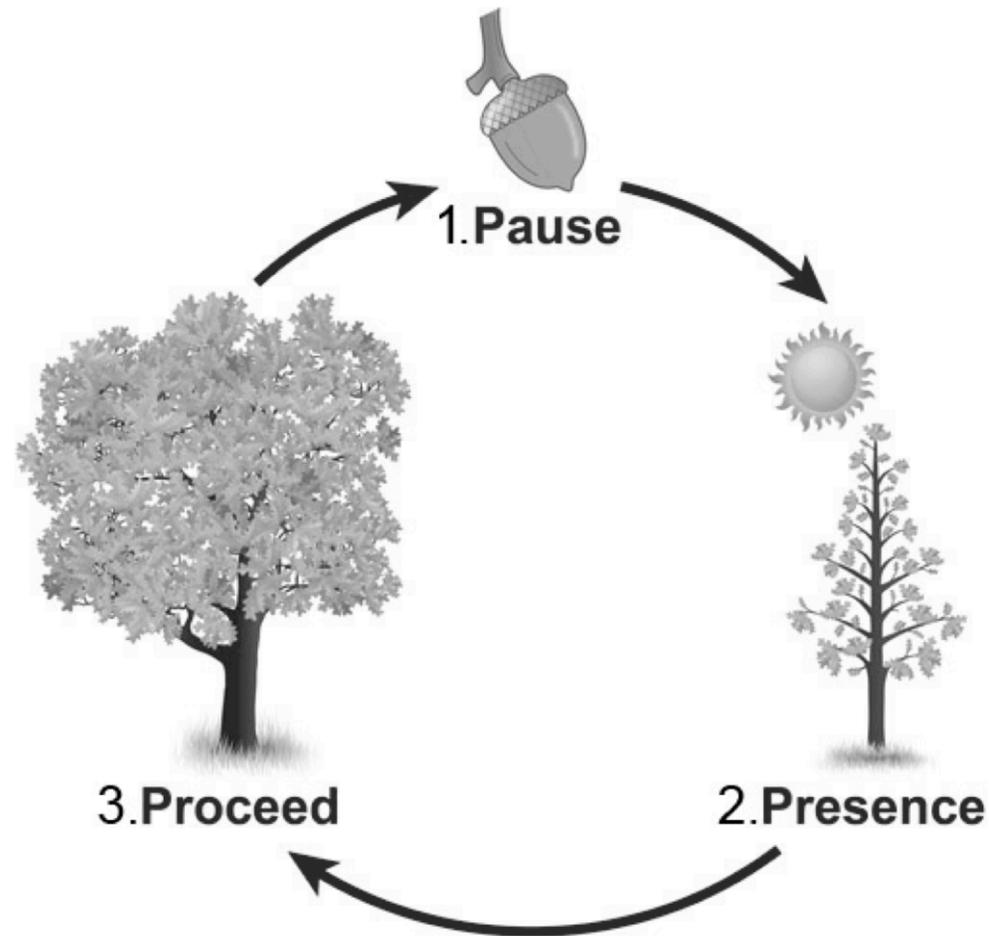
Being Aware of Our Own Responses:

- **Fear** of being overwhelmed or making bad decisions
- **Reluctance** to identify with “victim”
- **Helplessness** & inadequacy if can’t “fix” or predict outcomes
- **Frustration** with survivor for not responding to our needs to do a good job
- **Lack of attention** to personal history and vicarious trauma
- **Avoid, dismiss, blame, label, control**

Attending to Our Own Personal Experiences & Responses



3-Step Mindfulness Practice For Health Care Provider Burnout



University of Wisconsin Department of Family Medicine
<http://www.fammed.wisc.edu/>

Vicarious or Secondary Trauma

- An inevitable process of change that happens because you care about the people you serve, resulting in changes in your psychological, physical and spiritual life affecting you, your family, and your organization over time

Greg Merrill LCSW in collaboration with LEAP adapted from Pearlman & McKay Headington Institute

Transforming Secondary Trauma: ABCs

- **Awareness**

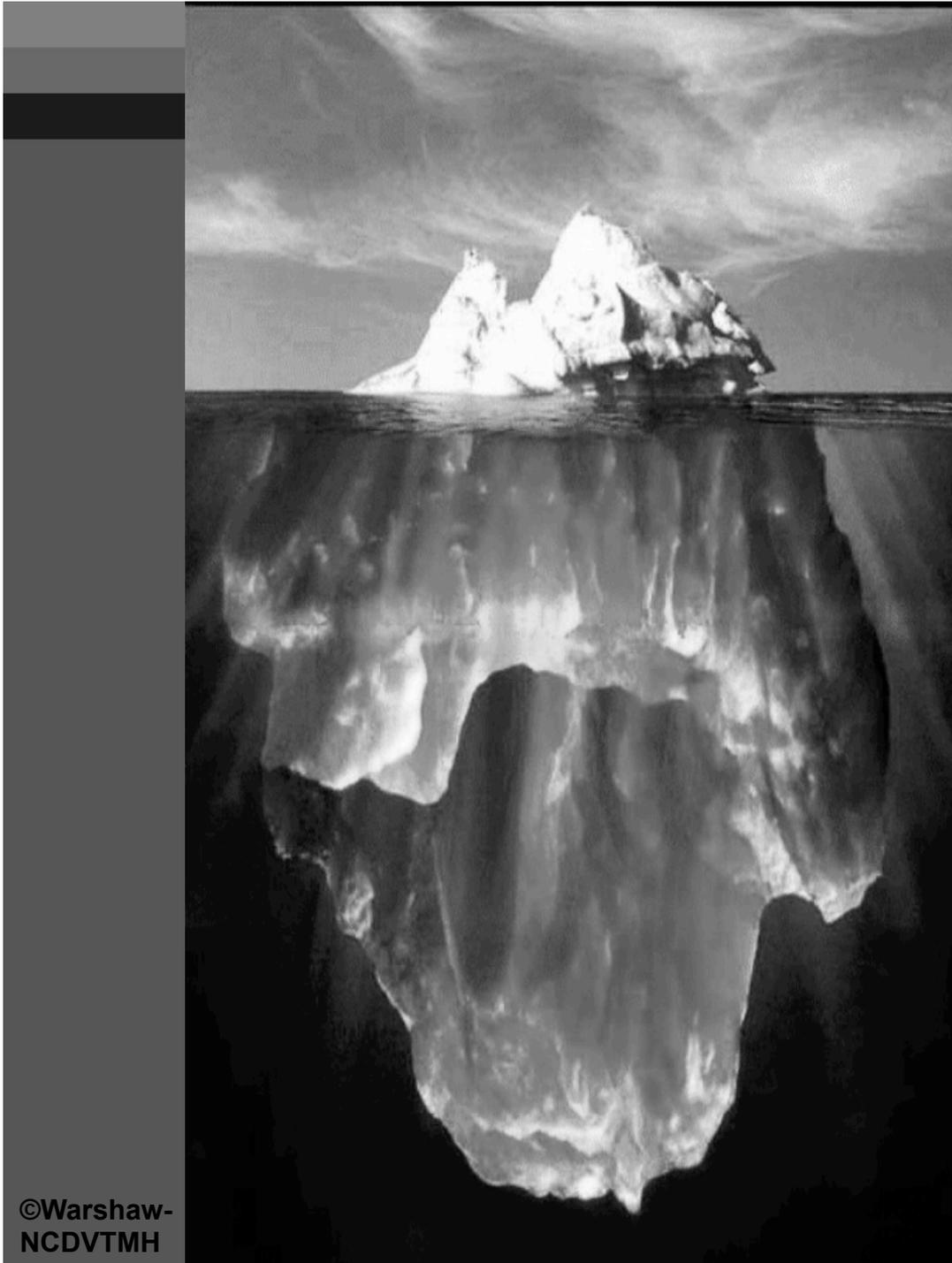
- Be attuned to one's needs, limits, emotions, resources
- Heed all sources of information—cognitive, physical, intuitive
- Practice mindfulness and awareness

- **Balance**

- Work, play and rest

- **Connection**

- To oneself, to others, and to something larger
- To things that are meaningful



**Thinking about
Transference &
Countertransference**

.....

**What May Be Below
the Surface...**

Trauma-Informed Organizations

- **Agency culture & commitment**
 - **Incorporate TI principles into every aspect of organization** mission, policies, training, staffing, HR policies, staff evaluation, environment, services and evaluation; consistent with patient-centered approach; incorporate staff & patient feedback; form community partnerships

- **Staff supports**
 - **Salaries, benefits, reasonable workload** expectations personal development, hiring; staffing patterns that allow back-up and sharing responsibility and coverage;
 - **Ongoing training;** Integrated mental health providers; Multidisciplinary team support; Community partnerships
 - **Adequate supervision:** Assume work will elicit strong feelings; Make a safe place in which to discuss them
 - **Attention to burnout and secondary trauma;** balance, self-awareness, & “self-care”

Other Strategies for Cultivating Awareness and Nurturing Empathy

- Time for reflection and quiet places
- Regular supportive supervision
- Team approach/Trauma champions
- Incorporation into staff meetings and case discussions
- Integration of trauma-informed mental health practitioners in medical settings
- Mindfulness practices
- Time for restorative activities on and off-site

Supports & Training for Staff

- **Regular reflective supervision**
 - Opportunities to think about things that come up in your interactions with patients and to notice and address how challenges that arise may be related to trauma
 - Opportunities to think about and address the impact of the work you do on your own life
- **Organizational culture** in which...
 - Everyone feels valued, empathy is nurtured, hierarchy is limited, tensions are addressed openly, there are no hidden agendas and there is a collective sense of purpose

Feedback and Evaluation

- There are procedures for soliciting regular input and **feedback from people who receive services** that is anonymous and confidential.
- Policies and procedures are in place for including **people who use services in an advisory capacity** to the agency.
- Exit evaluations or equivalent methods for soliciting feedback are available in the **languages used by a majority of the people served.**

Feedback and Evaluation

- The organization **evaluates whether staff members feel safe and valued.**
- Mechanisms are in place for **staff** to provide **feedback** on the organization's ability to provide for the physical and emotional safety of staff and people receiving services.
- The organization regularly **incorporates feedback** into changes and improvements.

Creating DV- and Trauma-Informed Practices & Institutions

Transforming the Conditions that Perpetuate Abuse & Oppression

Recognize Pervasiveness & Impact of Trauma

Minimize Retraumatization

Create Physical & Emotional Safety

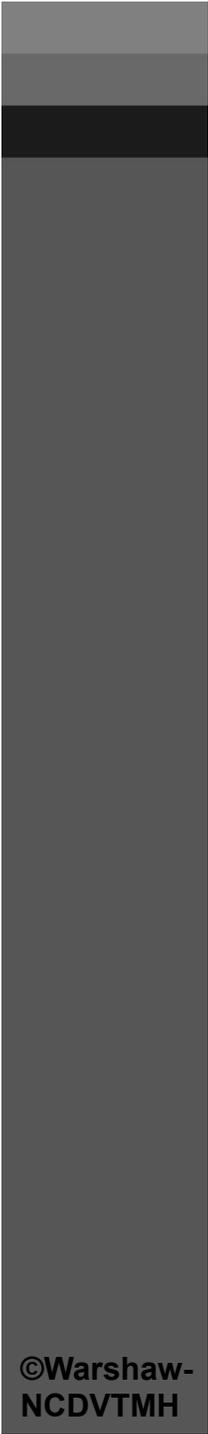
Attend to Organizational Culture & Environment

Talk About Trauma & Abuse in Context of TI Relationship

Create Institutional Supports; Promote Social Change

Attend to Impact on Providers & Organization

Support Resilience & Healing; Refer for DV Services & Trauma Treatment



**Being trauma informed
means embodying in our
own practices and
institutions the world we
want to create**



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