Trauma-Informed Care: Part One

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Potentially Traumatic Events

Interpersonal/Relational:

Political:

Crime:

Natural Disaster/Environmental:

Medical:

Other:
Scenario: Helen & Andrea (Saakvitne, et al., 2000)

Helen looked up from her paperwork as she heard the ambulance pull up. She dreaded this one. Andrea Miller, again. She sighed, straightened her shoulders, and went out to meet the EMT’s. She felt helpless and angry already.

In a few minutes she was sitting with Andrea. The doctor on call would be there shortly to suture Andrea’s arm. In addition to many superficial but bloody cuts, there were two deep gashes, all self-inflicted. Andrea was tearful and agitated. “I couldn’t sop myself. I had to do something. I had to see blood. I just couldn’t stand it any longer. I want to die. I tried drinking to numb out, but it didn’t help. I couldn’t stop crying and then I heard the voices saying, ‘I’ll give you something to cry about,’ and I knew I had to be hurt.”

Helen looked away from Andrea’s arm but didn’t want to meet her eyes. She didn’t know what to offer. Andrea had been in the emergency room five times this month already. Sometimes they had just kept her for a few hours until she calmed down. Three times they admitted her to the inpatient unit, and she only stayed a day or two. The staff at the hospital were always anxious to have Andrea discharged as soon as she calmed down. She was a “difficult” patient who demanded much and seemed helped by little.

The mental health staff knew it was only a matter of time before Andrea would present in crisis once again. No one seemed to hold any hope that there was a way to break out of the cycle.

“Where are your kids tonight?” Helen asked. Andrea responded tearfully, “They’re at home alone. I didn’t have anyone to call. I didn’t want them to see me like this. I left them with a video and told my eleven-year-old to watch the other two and put them to bed when the video was over. I know its bad, but I didn’t know what else to do.”

Helen promised to send out a worker to see the children. She winced inwardly as she thought about what the children might make of all this. When not in crisis, Andrea tried hard to be a good mother. She was fiercely protective and seemed fairly capable of meeting her children’s needs. Her parenting skills fluctuated, however, as Andrea became overwhelmed by the external stressors of poverty and boyfriends who were abusive, and the internal press of dissociation and despair. To Helen’s knowledge, Andrea had not abused her kids, but at times they were clearly neglected. Given how overwhelmed the child protective system was, these kids would be seen as a lower priority than kids in more immediate physical danger.

Helen knew Andrea needed something she wasn’t getting from existing services. She felt torn amid her feelings of compassion for Andrea, guilt at her own impotence, and anger at Andrea for not changing. In her frustration, Helen was silent.

Andrea looked up and said quietly, “You’re giving up on me aren’t you? I knew I’d wear you out. It really is hopeless, and now you’re pissed off with me too. I should just die!”

What do you think? Is there hope? What signs of hope do you see in this situation?
Symptoms of Trauma

Everyone experiences and responds to trauma differently. Survivors who exhibit trauma symptoms often present in one of four ways:

**SAD**
- Persistent sadness
- Suicidal thoughts or behaviors
- Low self-esteem
- Self-injury, appear to be self destructive or self sabotage
- Shame about the abuse
- Hopelessness and despair
- Feelings of isolation and withdrawal
- Helplessness

**MAD**
- Explosive anger and rage
- Hyper-sexuality
- Drug use and related behaviors
- Running away or truancy in adolescent
- Gang-related violence
- Preoccupation with revenge toward perpetrator
- Frequent physical fights
- Hostility toward authority figures

**BAD**
- Dissociative episodes
- Compulsions
- Depersonalization
- Obsessive thinking
- Feeling totally different from everyone
- Preoccupation with the perpetrator which may appear delusional
- Paranoia
- Eating disorders
- Intense guilt or shame

**“I’VE BEEN HAD”**
- Distrust and re-victimization
- Disrupted relationships
- Domestic violence
- Failure to protect oneself and accurately assess danger
- Pattern of succumbing to damaging peer pressure
- Difficulty in setting long-term goals due to sense of foreshortened future
### How Common Trauma Reactions May Explain Some “Difficult” Behaviors or Reactions within Homeless Service Settings (Hopper, E. K., et al., 2010)

<table>
<thead>
<tr>
<th>&quot;Difficult&quot; Behaviors or Reactions within Homeless Service Settings</th>
<th>Common Trauma Reactions</th>
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<tbody>
<tr>
<td>Has difficulty “getting motivated” to get job training, pursue education, locate a job, or find housing.</td>
<td>Depression and diminished interest in everyday activities</td>
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<td>Complains that the setting is not comfortable or not safe, appears tired and poorly rested. Is up roaming around at night.</td>
<td>Nightmares and insomnia</td>
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<td>Perceives others as being abusive, loses touch with current-day reality and feels like the trauma is happening over again.</td>
<td>Flashbacks, triggered responses</td>
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<td>Avoids meetings with counselors or other support staff, emotionally shuts down when faced with traumatic reminders.</td>
<td>Avoidance of traumatic memories or reminders</td>
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<td>Is alert for signs of danger, appears to be tense and nervous.</td>
<td>Hyper-alertness or hypervigilance</td>
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<td>Lacks awareness of emotional responses, does not emotionally respond to others.</td>
<td>Emotional numbing or restricted range of feelings</td>
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<td>Has difficulty keeping up in educational settings or job training programs.</td>
<td>Difficulty concentrating or remembering</td>
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<td>Becomes agitated within the shelter. Is triggered by rules and consequences. Has difficulty setting limits with children.</td>
<td>Feeling unsafe, helpless, and out of control</td>
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<tr>
<td>Has difficulty following rules and guidelines within the shelter or in other settings. Is triggered when dealing with authorities. Will not accept help from others.</td>
<td>Increased need for control</td>
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<td>Feels emotionally &quot;out of control.&quot; Staff and other residents become frustrated by not being able to predict how he or she will respond emotionally.</td>
<td>Affect dysregulation (emotional swings – like crying and then laughing)</td>
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<tr>
<td>Seems spacey or &quot;out of it.&quot; Has difficulty remembering whether or not they have done something. Is not responsive to external situations.</td>
<td>Dissociation</td>
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<td>Complains of aches and pains like headaches, stomachaches, backaches. Becomes ill frequently.</td>
<td>Psychosomatic symptoms, impaired immune system</td>
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<td>Cuts off from family, friends, and other sources of support.</td>
<td>Feelings of shame and self-blame</td>
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<td>Has difficulty trusting staff members; feels targeted by others. Does not form close relationships in the service setting.</td>
<td>Difficulty trusting and/or feelings of betrayal</td>
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<td>Complains that the system is unfair, that they are being targeted or unfairly blamed.</td>
<td>Loss of a sense of order or fairness in the world</td>
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<td>Puts less effort into trying--does not follow through on appointments, does not respond to assistance.</td>
<td>Learned helplessness</td>
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<td>Invades others' personal space or lacks awareness of when others are invading their personal space.</td>
<td>Boundary issues</td>
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<td>Has ongoing substance use problems.</td>
<td>Use of alcohol or drugs to manage emotional responses</td>
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<td>Remains in an abusive relationship or is victimized again and again.</td>
<td>Revictimization (impaired ability to identify danger signs)</td>
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### “Traditional” vs. Trauma-Informed Approach (Harris & Fallot, 2001)

<table>
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<th>Understanding trauma</th>
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<th>Trauma-Informed</th>
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<tr>
<td>Trauma is a single event the response to which is defined/diagnosed as PTSD.</td>
<td>Trauma makes the survivor question even the most fundamental assumptions about the world – in the wake of trauma he or she constructs a new theory of how the world works and how people behave.</td>
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<td>Impact is predictable.</td>
<td><em>Trauma is viewed not as a single discrete event but rather as a defining and organizing experience that forms the core of an individual’s identity.</em></td>
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<td>Practitioners assume that trauma changes the rules of the game.</td>
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<th>Understanding the consumer survivor</th>
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<tr>
<td>The consumer and her or his problems are synonymous.</td>
<td>Emphasis is on understanding the whole individual and appreciating the context in which she lives her life. (“How do I understand this person?” rather than “How do I understand this problem?”)</td>
<td></td>
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<tr>
<td>The problem has a life of its own, independent of context.</td>
<td>Trauma-related symptoms arise as attempts to cope with intolerable circumstances and those symptoms emerge in a context of abuse.</td>
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<td>There is a blurring of the distinction between a problem and a symptom.</td>
<td>Consumer-survivor evaluates her responsibility for change – not a passive victim.</td>
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<td>Allocation of responsibility on the consumer is either too great or too little.</td>
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<td>In many cases, the only viable goal is stabilization (in most efficient manner possible) – once symptoms have been managed, treatment ends.</td>
<td>The goal is to return a sense of control and autonomy to the consumer-survivor.</td>
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<tr>
<td>Services are crisis-driven.</td>
<td>Emphasis is on skill-building and only secondarily on symptom management.</td>
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<td>System strives to minimize risk to itself.</td>
<td>Service time limits are set in collaboration with the consumer-survivor.</td>
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<td>Services are content specific, time limited, and outcome focused.</td>
<td>Services are strengths-based.</td>
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<th>Understanding the service relationship</th>
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<tr>
<td>Consumer is passive recipient of services.</td>
<td>Core of the service relationship is a genuine collaboration.</td>
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<td>The provider is accorded more status and power within the relationship.</td>
<td>Trust must be earned.</td>
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<tr>
<td>Consumers often find themselves frightened and cautious.</td>
<td>Provider and consumer both bring strengths to the relationship.</td>
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<tr>
<td>Trust is assumed.</td>
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Trauma-Informed Care – Shared Assumptions (Bloom, 1997)

1. People begin life with normal potentials for growth and development, given certain constitutional and genetic predispositions, and then become traumatized. “Posttraumatic stress reactions are essentially the reactions of normal people to abnormal stress” (Silver, 1986).
2. When people are traumatized in early life, the effects of trauma frequently interfere with normal physical, psychological, social, and moral development.
3. Trauma has biological, psychological, social, and moral effects that spread horizontally and vertically, across and down through generations.
4. Many symptoms and syndromes are manifestations of adaptations, originally useful as coping skills, that have now become maladaptive or less adaptive than originally intended.
5. Many victims of trauma suffer chronic post-traumatic stress disorder and may manifest any combination of the symptoms of PTSD.
6. Victims of trauma can become trapped in time, their inner experiences fragmented. They are caught in the repetitive re-experiencing of the trauma, which has been dissociated and remains un-integrated into their overall functioning.
7. Dissociation and repression are core defenses against overwhelming affect and are present, to a varying extent, in all survivors of trauma.
8. Although the human capacity for fantasy and elaboration and imaginative creation are well-established, memories of traumatic experiences must be assumed to have at least some basis in reality.
9. Stressful events are more seriously traumatic when there is an accompanying helplessness and lack of control.
10. Traumatic experience and disrupted attachments combine to produce defects in the regulation and modulation of affect, of emotional experience. Human beings require other human beings to respond to their emotions and to help contain feelings that are overwhelming.
11. People who are repeatedly traumatized may develop “learned helplessness,” a condition that has serious biochemical implications.
12. Trauma survivors often discover that various addictive behaviors restore at least a temporary sense of control over intrusive phenomena.

13. Survivors may also become addicted to their own stress responses and as a result compulsively expose themselves to high levels of stress and further traumatization.

14. Many trauma survivors develop secondary psychiatric symptomatology and do not connect their symptoms with previous trauma. They become guilt ridden, depressed, and exhibit low self-esteem and feelings of hopelessness and helplessness.

15. Trauma victims often have difficulty managing aggression. Many survivors identify with the aggressor and become victimizers themselves. A vicious cycle of transgenerational victimization often ensues.

16. The more severe the stressor, the greater the likelihood of post-traumatic pathology. The same is true the more prolonged the exposure to the stressor, the more impaired the social support system, and the greater the degree of exposure to or involvement in previous trauma.

17. Attachment is a basic human need from cradle to grave. Enhanced attachment to abusing objects is seen in all studied species, including humans.

18. Childhood abuse often leads to disrupted attachment behavior, inability to modulate arousal and aggression toward self and others, impaired cognitive functioning, and impaired capacity to form stable relationships.

19. Although it may be a lifelong process, recovery from traumatic experience is possible. Over the course of recovery, survivors may temporarily need safe retreats within which important therapeutic goals can be formulated and treatment can be organized.

20. We are all interconnected and interdependent, for good or for ill. Safety must be constantly created and maintained by everyone in the community as a shared responsibility.

21. The whole is greater than the sum of the parts.
Exercise: Laura’s Story (adapted from www.ThinkT3.com)

Please read the story of Laura below. Then note the following:
(1) Circle the traumatic experiences.
(2) Label what they are in the margins.
(3) Underline places where Laura exhibits strengths.
(4) Name each strength by writing it in the margin.
(5) Answer the questions at the end of the story.

Laura’s family included her mom, an older sister, and an older brother. Her dad left when she was very young. The family lived in a poor neighborhood marked by gang violence. Among the most thriving businesses was cocaine. Laura’s mom’s main source of income was baby-sitting the neighbor’s children. She also received food stamps and some TANF money. By the end of the month, though, the family often had little money for food. Laura fought with her sister and brother about sharing the last of the groceries. As a baby, Laura’s cries weren’t always answered. Her mom was seriously depressed and self-medicated with alcohol. Sometimes she could care for Laura, but often that task fell to someone else.

Laura had many caregivers, but none of them were reliable or safe all the time. They included her mom’s boyfriend and drinking buddies, the neighbor across the hall, and her siblings. Her brother, Carl, resented Laura for diverting their mother’s already-limited attention. Her big sister, Tasha, was the most reliable, but she was young herself and couldn’t always protect Laura from the violent fights between their mom and her boyfriend. Sometimes, Laura tried to stop these fights, but that usually led to her being hit as well. “Mind your own business,” her mom would say. The next morning, though, her mom would crawl into bed with her and hold her tightly, apologizing for the scary scenes of the night before and telling her that soon she would have enough money to find a new, safer place to live.

Laura’s life continued to be marked by disruption and violence. She learned that asking for help was a sign of weakness. “You gotta fend for yourself, little girl,” her mom would say to her, laughing. Taking this to heart, she tried to do everything herself. She had nightmares and a constant stomachache, but didn’t tell anyone. If she messed up in school, the anxiety she felt was almost unbearable. She had several boyfriends, but none treated her well. “At least they don’t hit me,” she’d tell herself after particularly bad fights.

She graduated from high school. Her anxiety became worse. She began drinking excessively, just to feel her body relax. Soon, she was a “regular” when her mom’s drinking buddies came for a visit. She justified these binges by saying it was a “bonding experience” with her mom. Her boss at the local grocery store did not agree and eventually had to fire Laura for missing so much work. Her family was of no help. She moved in with her on-again, off-again boyfriend. Eventually, she moved to the streets.

Please answer the questions on the next page...
What are Laura’s risks factors for homelessness?

What symptoms of/adaptations to a traumatic response is Laura exhibiting? What might there adaptive function be? How might these help Laura?

What may become triggers for Laura?

What would Laura need in order to begin trusting us?
May You Be Blessed

May you be blessed
With discomfort at easy answers,
Half-truths, and superficial relationships,
So that you will live
Deep in your heart.

May you be blessed
With anger at injustice, oppression, and
Exploitation of people and the earth
So that you will work for
Justice, equity, and peace.

May you be blessed
With tears to shed for those who suffer
So you will reach out your hand
To comfort them and
Transform their pain into joy.

And may you be blessed
With the foolishness to think
That you can make a difference in the world,
So you will do the things
Which others say cannot be done.

Source Unknown
**Trauma-Informed Care Bibliography – September 2011**

**Understanding Trauma**


Treatment & Recovery


Trauma and Substance Use


Impact of Trauma Work


Trauma-Informed Organizational Assessments & Toolkits


Websites:

Adverse Childhood Experiences Study: http://www.acestudy.org/

Community Connections (includes TREM, M-TREM): http://www.communityconnectionsdc.org/

International Society for Traumatic Stress Studies: http://www.istss.org/Home1.htm


PTSD Alliance: http://www.ptsdalliance.org/

SAMHSA National Center for Trauma-Informed Care: http://www.samhsa.gov/nctic/

Seeking Safety: http://www.seekingsafety.org/

Sidran Institute: http://www.sidran.org/

t3 Training: think-teach-transform: http://www.center4si.com/training/index.cfm

Trauma Focused Cognitive-Behavioral Therapy (TF-CBT) Training: http://tfcbt.musc.edu/

Trauma-Informed Response: http://www.traumainformedresponse.com/Home.html

Trauma Stewardship: http://traumastewardship.com/

Traumatic Stress Institute: http://traumaticstressinstitute.org/

Veterans Administration: http://www.ptsd.va.gov/