Trauma-Informed Care: Part Two

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How might a survivor you know complete these stems?

- The world is...
- They always think I...
- I will never be...
- Because of me...
- I am...
- If they really cared...
Impact of Trauma: World View

- The world is an unsafe place in which to live.

- Other people are unsafe and cannot be trusted.

- Own thoughts and feelings are unsafe.

- Anticipate(expect continued crises, danger and loss.

- Lack of belief in self-worth and capabilities.
Impact of Trauma: Accessing/Receiving Services

“I had been coerced intro treatment by people who said they’re trying to help...These things all re-stimulated the feelings of futility, reawakening the sense of hopelessness, loss of control I experienced when being abused. Without exception, these episodes reinforced my sense of distrust in people and belief that help meant humiliation, loss of control, and dignity.”

- Laura Prescott

Impact of Trauma Endures:

In the beginning is my end. (T. S. Elliot, 1943)

“In the context of everyday medical practice, we came to recognize that the earliest years of infancy and childhood are not lost, but like a child’s footprints in wet cement, are often lifelong” (Felitti & Anda, 2010).
“Traumatic events call into question basic human relationships. They breach the attachments of family, love, and community. They shatter the construction of the self that is formed and sustained in relation to others. They undermine the belief systems that give meaning to human experience. They violate the victim’s faith in a natural or divine order and cast the victim into a state of existential crisis” (Herman, 1997, p. 52).
Why Trauma-Informed?

Misunderstood or ignored signs of trauma may:

- Interfere with help-seeking
- Limit engagement into services
- Lead to early drop out
- Inadvertently re-traumatize people we are trying to help
- Failure to make appropriate referrals
Trauma-Informed Care

- We **assume** that all people with whom we work have experienced and survived trauma, to avoid inadvertently or unnecessarily re-traumatizing them.

- We **acknowledge** that trauma comes in many forms.

- We **recognize** that the experience of trauma can impact how people think about and respond to themselves, events, people, and circumstances.
Re-Traumatizing Clients

- Re-experiencing original trauma (symbolically or actually).

- Client responds as if there is danger even if it is not actual danger.

- Triggers may be subtle and difficult to identify.
Trauma-Informed Services

“Understanding, anticipating, and responding to the issues, expectations, and special needs [that each trauma-survivor may have]. At minimum, trauma-informed services should endeavor to do no harm...”

Implementing and Practicing
Trauma-Informed Care

“The agency that is determined to inform all of its staff about trauma dynamics would do well to postpone intensive training for a few in favor of a more general introduction for many. A trauma survivor who seeks services may interact with a dozen individuals before actually sitting down with a clinician trained to provide trauma services. A woman will have to make an appointment and speak with a receptionist. A man will enter the agency and walk past a security guard or a maintenance worker. A family may stop for a snack at the hospital cafeteria. Once they are in the agency they may encounter office workers, intake personnel, trainees, and anonymous clinicians. Any of these individuals has the opportunity to make a consumer’s visit to the service agency inviting or terrifying” (Harris & Fallot, 2001, p. 7).
Transformation at Every Level
## COMPARING APPROACHES

<table>
<thead>
<tr>
<th>“Traditional”</th>
<th>Trauma-Informed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems/Symptoms are discrete and separate.</td>
<td>Problems/symptoms are interrelated responses or coping mechanisms to deal with trauma.</td>
</tr>
<tr>
<td>Hierarchical.</td>
<td>Shares power/limits hierarchy.</td>
</tr>
<tr>
<td>Client behavior is characterized as “manipulative” or “working the system.”</td>
<td>Client behaviors are viewed as adaptations or ways to get needs met.</td>
</tr>
<tr>
<td>Service providers are (the only) experts.</td>
<td>Clients are invited as active experts and partners with service providers.</td>
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Adapted from L. Prescott
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<td>Primary goals are defined by service providers and focus on symptom reduction.</td>
<td>Primary goals are defined by clients and focus on recovery, self-efficacy, resilience, strengths, and healing.</td>
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<tr>
<td>Reactive: Services and symptoms are crisis driven and focused on minimizing liability.</td>
<td>Proactive: Preventing further crisis and avoiding re-traumatization. Advanced directives.</td>
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<tr>
<td>Sees clients as broken, vulnerable, and needing protection from themselves.</td>
<td>Understands providing choice, autonomy, control, and opportunities for collaboration is central to healing.</td>
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Trauma-Informed “Lens”

- “Trauma glasses”
- “Trauma first”
- Listening with a trauma framework
- *How is this related to trauma?*
- Trauma comes in many forms
- How do I understand this *person* vs. this problem or symptom?
- Symptom Handout (Hopper et al., 2010)
Language Matters: Trauma in Conversation

Word choice communicates feelings and value

- labels vs. descriptions
- behavior vs. identity
- circumstance vs. person
- victim, survivor, thriver
- “if...then” language
- working metaphors
“During every incarceration, every institutionalization, every court-ordered drug treatment program, it was always the same: I was always treated like a hopeless case. All people could see was the way I looked or the way I smelled. It wasn’t until I finally entered a recovery-oriented, trauma-informed treatment program a little more than four years ago, when I felt safe and respected, that I could begin to heal...Someone finally asked me ‘What happened to you?’ instead of ‘What’s wrong with you?’”

--Tonier Cain
1. Symptoms are adaptations.

2. Trauma shapes the survivor's basic beliefs about identity, world view, and spirituality or meaning-making.

3. Using a trauma framework, the effects of trauma can be addressed within mental health (and substance use) treatment systems.

4. When worker and client share a trauma perspective, they can collaborate.

5. The four most important things a worker has to offer a survivor are Respect, Information, Connection, and Hope (RICH).

6. Workers need support from one another, including Respect, Information, Connection, and Hope.

7. Working with survivor clients affects the person of the helper too.
Symptoms are Adaptations

- A trauma-informed model frames survivors’ symptoms as adaptations, rather than as pathology.
- Every symptom helped a survivor in the past and continues to help in the present — in some way.
- Emphasizes resilience in human response to stress.
- Reduces shame.
- Engenders hope for clients and providers alike.

“Successful treatment should help the client to do better what he or she is already attempting to do” (Briere, 2002, p. 24).
Symptoms are Adaptations

“Exploring the reasons underlying the high prevalence of patients inexplicably fleeing their own success in the program ultimately led us to recognize that weight loss is often sexually or physically threatening and that certain aspects of the more intractable public health problems such as obesity were also unconscious, or occasionally conscious, compensatory behaviors that were put in place as solutions to problems dating back to the earliest years, but hidden by time, by shame, by secrecy, and by social taboos against exploring certain areas of life experience” (Felitti & Anda, 2010, p. 77).

“…[W]hat one sees, the presenting problem, is often only the marker for the real problem, which lies buried in time, concealed by patient shame, secrecy, and sometimes amnesia – and frequent clinician discomfort…All told, it is clear that adverse childhood experiences have a profound, proportionate and long-lasting effect on emotional state, whether measured by depression or suicide attempts, by protective unconscious devices such as somatization and dissociation, or by self-help attempts that are misguided addressed solely as long-term health risks – perhaps because we physicians are less than comfortable acknowledging the manifest short-term benefits these ‘health risks’ offer to the patient dealing with hidden trauma” (Felitti & Anda, 2010, p. 80).

**Respect:** Validate survivor experiences; reduce shame; place priority on safety, choice and control; use person’s language to talk about trauma; normalize behaviors in a non-judgmental way; emphasize resiliency in human responses to stress

**Information:** *INQUIRE & LISTEN*; Provide resources; support empowerment & skill development

**Connection:** Healing power of relationships and being connected to others; open & collaborative

**Hope:** For the people we serve and workers alike
Relationships Matter...

Workers are more likely to make this meaningful connection if they understand the ever present role trauma plays in undermining the foundation of trust and shattering relationships in the lives of people who are homeless. **Because trauma very often happens in the context of relationships, it is within relationships that healing must necessarily commence.**

(Fisher & Prescott, 2010)
Trauma-Informed Framework (Harris & Fallot, 2009; NHCHC, 2010)

- **Safety**: Ensuring physical & emotional safety; “Do No Harm”
- **Trustworthiness**: Relationships take time; Trust is earned; Making tasks clear; Managing boundaries
- **Choice**: Prioritizing consumer choice & control over services & recovery
- **Collaboration**: Maximizing mutuality & reciprocity; Sharing power; “Consultation between experts”
- **Empowerment**: Identifying & supporting autonomy & independent action; Building skills that promote recovery; “Mining” and highlighting inner strengths & resources
“As [survivors] come to see the power in their defenses and coping strategies, they also come to believe that they have the strength and wisdom to make changes in their lives...Within a trauma-informed system, the consumer-survivor reevaluates her responsibility for the changes and decisions she must make. She is not the passive victim who was abused back then and has no power now; nor is she the fully responsible adult who can take charge now and should have been more forceful back then. The trauma survivor recognizes that the blame for past abuse rests with the perpetrator and the system that allowed the abuse to go on. She also recognizes that the responsibility for change now lies with her and those she chooses to make collaborators in her recovery. The distinction between blame and responsibility allows a trauma survivor to assume balanced and appropriate authority for her future” (Harris & Fallot, 2001, p. 15).
What does all of this mean for our work?

- We work to establish relationships with people who may have been humiliated, hurt or betrayed by those who are supposed to be counted on for safety and protection.

- What are the challenges in engaging people when providers have proven untrustworthy in the past?

- What responsibilities do we have when engaging people in a relationship?
Power & Control (Harris & Fallot, 2001)

- Betrayal often occurs at the hands of a trusted caregiver or supporter.
- Hierarchical boundaries are violated and then re-imposed at the whim of the abuser.
- Secret knowledge, secret information, and secret relationships are maintained and even encouraged.
- The voice of the victim-survivor is unheard, denied, or invalidated.
- The victim-survivor feels powerless to alter or leave the relationship.
- Reality is constructed to represent the values and beliefs of the abuser. Events are reinterpreted and renamed to protect the guilty.
The Role of Power in the Provider Relationship

- As a provider we hold power.

- People who have experienced trauma have learned how to survive relationships with others who have more power so that they are able to get their needs met.

- Expect people to “tell us what we want to hear” and “do the right thing.” We can model a new way.
Trust and Being Trustworthy

- On-going process – trust is also the internal process of trusting one’s self
- Assume distrust is earned and honor that distrust
- Own mistakes, acknowledge them and fix mistakes when possible (be the opposite of the perpetrator)
A Trauma-Informed Approach Means:

- Asking people about their experience of trauma; completing a trauma screening or assessment.

- Developing treatment plans with trauma history in mind so that re-traumatization is kept to a minimum.

- Recognizing and respecting when a person is not ready to discuss trauma experiences.
A Trauma-Informed Approach Means:

- Offering trauma-specific interventions or access to such services.
- Assessing and planning for current safety needs.
- Acknowledging persons’ resilience as a survivor and building on these skills.
- Providing people opportunities to master their trauma experiences such that daily activities are not impacted.
- Recognizing the signs and symptoms of the impact of trauma work and developing mechanisms to support staff.
- Revising policies and procedures to reduce barriers to providing services and employing trauma survivors.
**TIC Best Practices**

- Be aware and sensitive to trauma and it’s impact.
- Explain why you are asking about trauma experienced.
- Recognize when someone is becoming re-traumatized and provide needed supports.
- Assess current safety and *collaboratively* develop plans and skills to establish safety.
- Connect consumer to community supports; build support network.
TIC Best Practices

- Know your areas of expertise. If the person chooses, establish connections to trauma-specific services available in the community.
- Recognize trauma impacts individuals differently – signs and symptoms of traumatic response may vary as well as onset of symptoms; many individuals exposed to traumatic events will not experience troublesome symptoms as a result of exposure.
- Ask the person what support they have found helpful in the past.
- Acknowledge the resiliency needed to survive trauma and build on these skills and strengths.
The Role of the “Enlightened Witness”

“Talking about the worst secret of one’s life with an experienced person, being understood and coming away feeling still accepted as a human being seems to be remarkably important and beneficial... Examiners have learned that the most productive response to a ‘Yes’ answer is, “I see that you have...Tell me how that has affected you later in your life.’...[T]he role of the ‘enlightened witness’” (Felitti & Anda, 2010, p. 85).
TIC Best Practices: Housing (Bebout, 2001)

- Trauma-Informed Housing Assessment
- Maximizing Choice
- Respecting Privacy Needs, Promoting Healthy Boundaries
- Advanced Directives
- Adaptive Self-Soothing
- Staff Training & Supervision
- Gender Specific Housing
- Clear Statement of Rules & Expectations
- Collaborative Decision Making
TIC Best Practices: Case Management
(Freeman, 2001)

- Approaches to treatment planning/service contracting
- Crisis planning and response
- Money Management
- Addressing/changing other potential forms of coercion (e.g., contingent housing, medication, treatment)

1. Early trauma derails a child’s development of self-capacities.

2. Collaboration in problem solving and creating safety is essential.

3. The helper’s basic response needs to be grounded in a respectful, relational approach in which the client is offered respect, information, connection, and hope.

4. Every symptom – or crisis – reflects a survivor’s attempted solution to a problem.

5. In every intervention, our goals are to use the relationship or alliance to separate the client’s traumatic past from his or her present experience.
Help the survivor separate the past from the present (grounding).

Help the survivor exercise control and choice.

Help the survivor stay connected or regain connection to positive others.

Help the survivor, whenever possible, to recognize the connection between past experiences and present behaviors and feelings.

- Extend assessment of HRS to include emotional states similar to the trauma/related cues
- Additional emphasis on/attention to self-efficacy/self-confidence
- Anticipate intensified AVE
- Continuing care
Akasha and her children are new to the shelter. They lived in a car for a couple of weeks and haven't had access to a bathroom and shower facilities in a while. They arrive at the shelter wearing clothes that are turned inside out and covered in sweat. After three days, she and her children still had not showered or changed. Other residents are beginning to complain to the staff.

Maria, a case manager, approaches Akasha and in a friendly voice says, “Hi, my name is Maria, what's yours?” while extending her hand. Akasha doesn't look up or make any motion to indicate that she sees Maria standing there. Maria continues, “I know it's been hot out there. Maybe you and the kids would like to use the shower.” Akasha becomes immediately angry and says, “I don't need a damn shower and neither do my kids.” She then storms toward her room.

At a staff meeting later that day, the staff discuss ways to approach and engage Akasha.
Rose says the shelter should call the mental health emergency services team to conduct an assessment. Her belief is that Akasha probably has some sort of psychiatric problem.

Carla wonders if Akasha was taking medication and has stopped. She also suggests that the new resident is withdrawing from drugs and that is why she is a bit edgy and withdrawn.

Maria wants to ask what is making Akasha so angry. Is she frightened? Does she feel unsafe? Did something happen?

Carla and Rose disagree with Maria’s approach. They think that only professionals should ask Akasha about her anger. They feel unqualified to ask her in-depth questions about her life. In addition, Carla and Rose are concerned that Akasha will scare the other residents and children. They express uncertainty about whether the shelter should have admitted her at all or if she would be better served by the mental health system.

1. **Who is thinking in a trauma-informed way? What makes their approach trauma-informed?**

2. **Who is approaching Akasha more traditionally? What makes this approach traditional?**

3. **What might have been going on that could explain Akasha’s response? What might be some possible remedies or alternative ways of addressing this issue?**

4. **How would our answers to the above questions change if we knew that Akasha’s batterer had beaten her while she and her children tried to hide in the shower?**
“The [survivor’s] recovery is not based on the illusion that evil has been overcome, but rather on the knowledge that it has not entirely prevailed and on the hope that restorative love may still be found in the world” (Herman, 1997, p. 211).
Provider Perception’s
(Najavits, 2002)

“Through my work I have continued to become a better human being, not just a better therapist.”

“As difficult as it is, this work pushes me to find new aspects of my own humanity, to honor that, and then to turn it around and use it to help my clients – they are my teachers!”

“Take Home” Exam: Dwelling on Days that Make Me Want to Come Back