

Trauma Informed Care



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Center

#2016TCC

Est. 1969



Sue Marasco



- ▶ Understanding trauma. How adverse experiences turn into diagnoses and what that looks like in the people we serve.
- ▶ How trauma informed care is a philosophy is used as a universal precaution to prevent re-traumatizing.
- ▶ How trauma informed care is also self-care for professionals in the helping professions.



Potential Traumatic Events

Abuse

Emotional

Sexual

Physical

Domestic violence

Witnessing violence

Bullying

Cyberbullying

Institutional

Loss

Death

Abandonment

Neglect

Separation

Natural disaster

Accidents

Terrorism

War

Invasive Medical Procedure

Chronic Stressors

Poverty

Housing Insecurity

Food Insecurity

Community trauma

Inconsistent Authority

Arbitrary Authority

Living with Mental Health Concerns

Living with Substance Use Disorder



How not to have PTSD

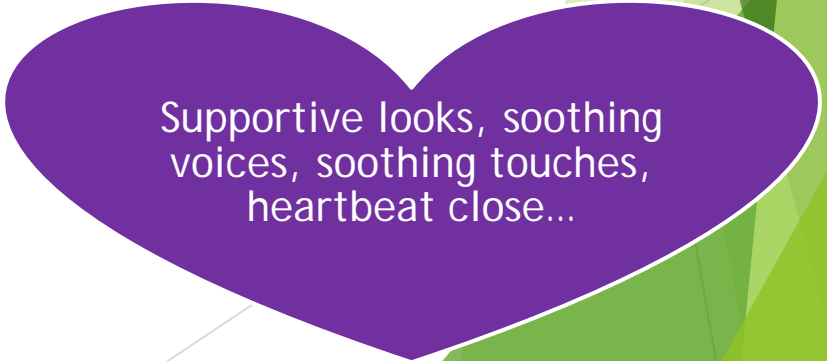




Terrible
Event



Immediate
Acknowledgement
of trauma



Supportive looks, soothing
voices, soothing touches,
heartbeat close...



Body safe: food,
water, sleep



Community
acknowledging
wrong,
providing
support



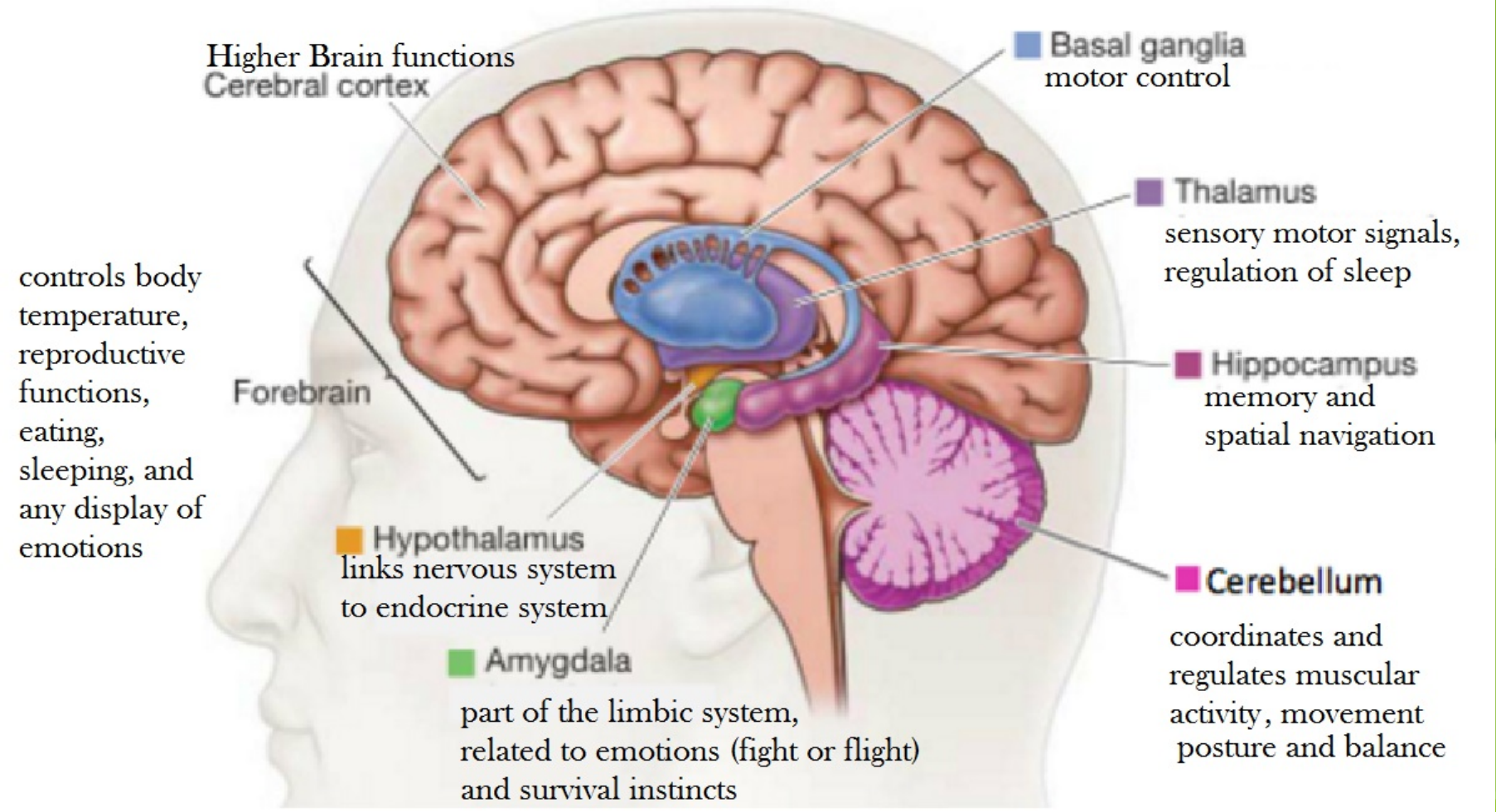


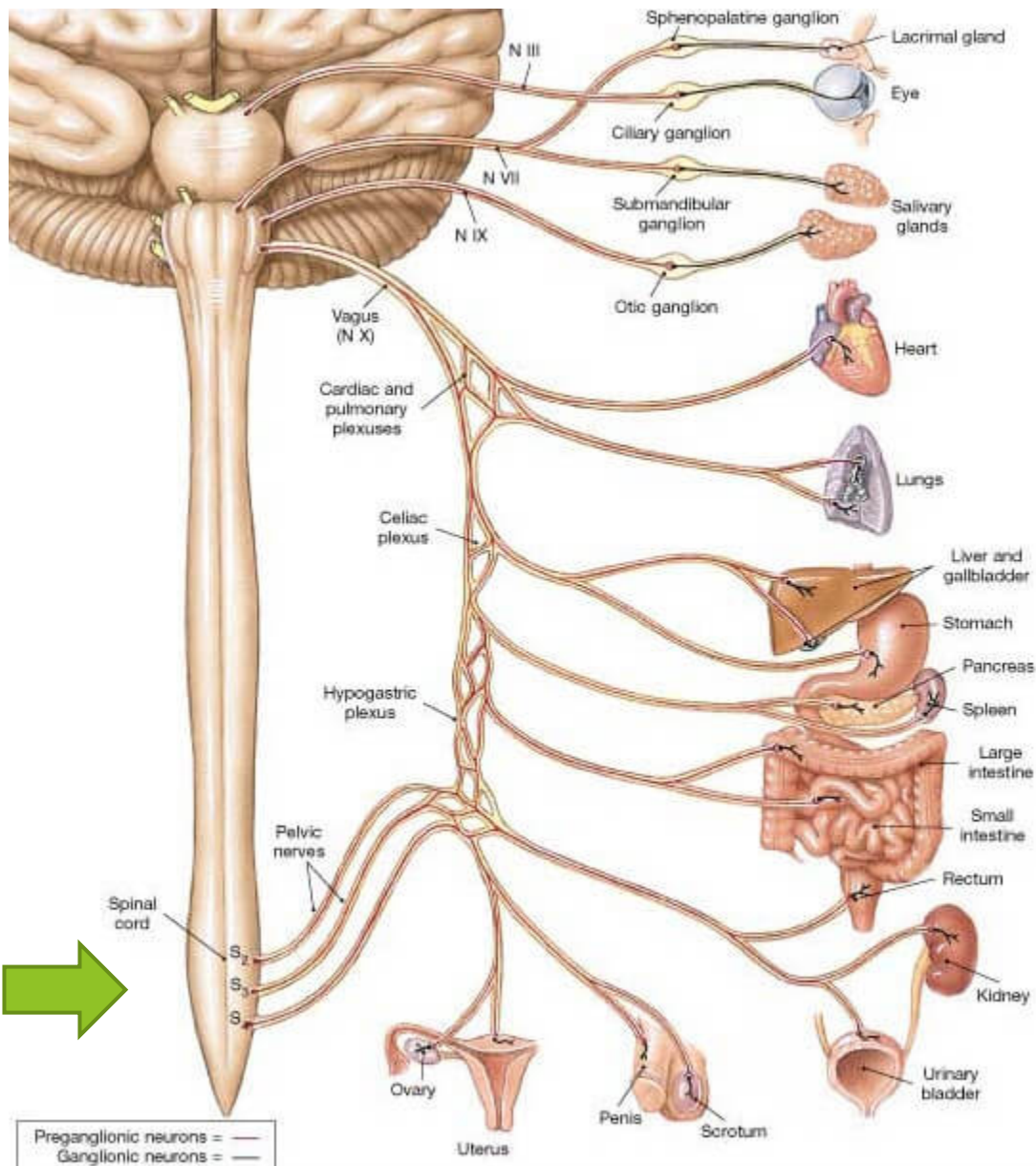
- ▶ What stress and trauma do to the body and brain

Brought to you by: [Center on the Developing Child at Harvard University](#)

- ▶ <https://www.youtube.com/watch?v=rVwFkcOZHJw>

We know trauma is stored in the Lymbic System



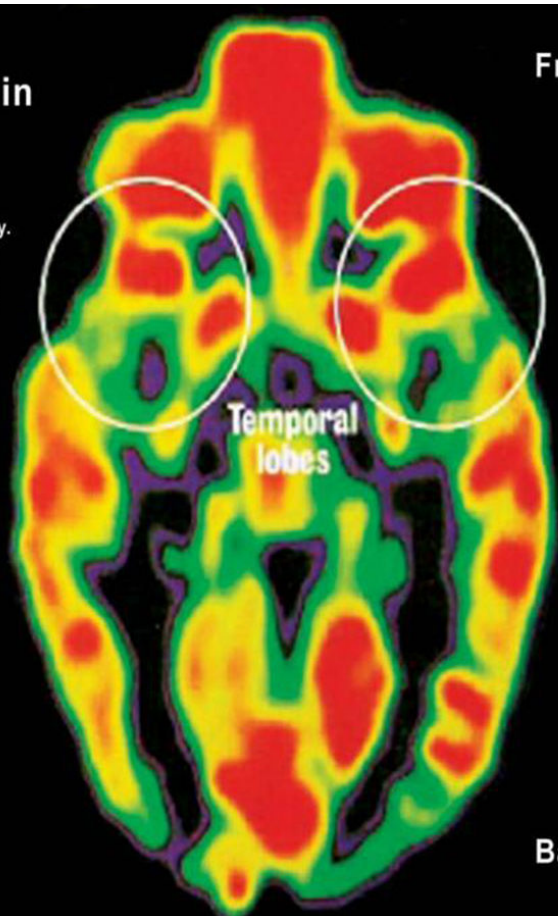


Parasympathetic Innervations



Healthy Brain

This PET scan of the brain of a normal child shows regions of high (red) and low (blue and black) activity. At birth, only primitive structures such as the brain stem (center) are fully functional; in regions like the temporal lobes (top), early childhood experiences wire the circuits.

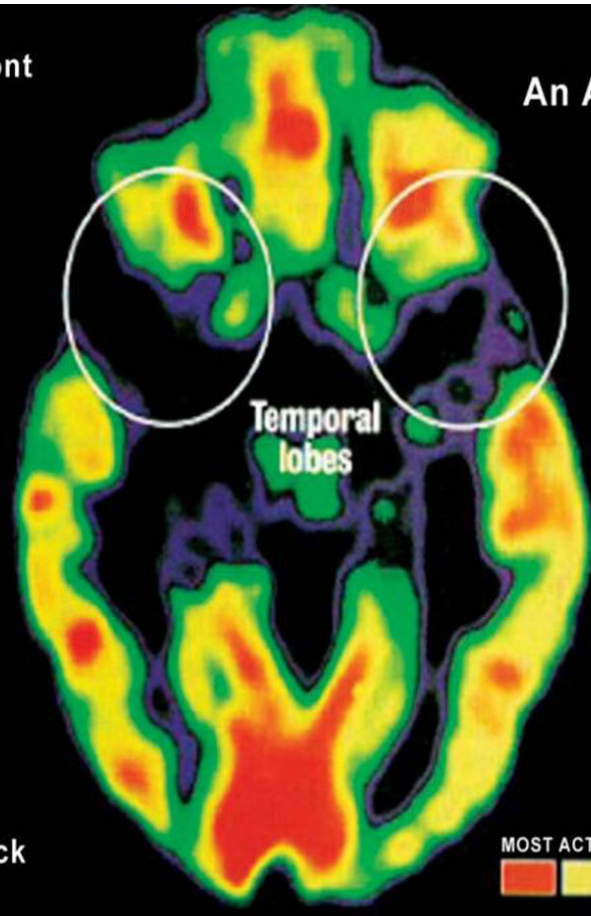


Front

Back

An Abused Brain

This PET scan of the brain of a Romanian Orphan, who was institutionalized shortly after birth, shows the effect of extreme deprivation in infancy. The temporal lobes (top), which regulate emotions and receive input from the senses, are nearly quiescent. Such children suffer emotional and cognitive problems.





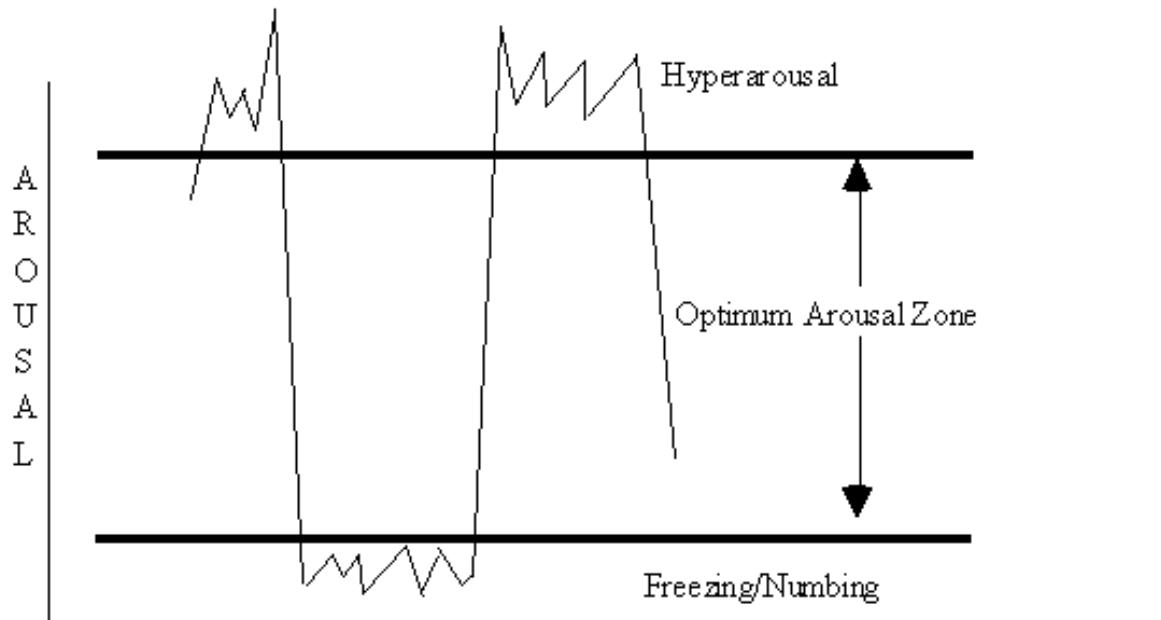
- ▶ Fight - Non-compliant or combative OR struggling to hold on to some personal control/power?
- ▶ Flight - Treatment resistant, uncooperative OR disengaging, withdrawing or titrating external stimulus/demands
- ▶ Freeze-Actual fixed state in physical, verbal, and mental capacities. Inability to process or outwardly react
- ▶ Submit- Passive, unmotivated OR giving in to those in power, repeating cycle of surrender in order not to get hurt

Behavior follows:

- ▶ Triggering results in fight, flight, freeze, submit:
- ▶ Threat perception: seeing threats where other people see manageable situations.
- ▶ Filtering system is compromised: hard to decide what is relevant and what can be dismissed.
- ▶ Self sensing system: midline structures devoted to experience of yourself gets blunted.
 - Can result in loose motor control, loss of fine-motor control (a person can look or act drunk/high without being so)
- ▶ Loses a sense of time.
- ▶ Lack of predictability in outcomes.
- ▶ Auditory (maybe visual) hallucinations
- ▶ Seeking out traumatic environments, unsafe people.

Or, to summarize

- ▶ **States become traits:** “If the neurobiology of specific response, hyperarousal or dissociation, is activated long enough, there will be molecular, structural and functional changes in the system.” --Bruce Perry



Trauma and Stress Particular to the HIV+ Community in Cleveland



“Report analyzes experiences of 1253 survivors of hate violence...”

A report from the National Coalition of
Anti-Violence Programs

**LESBIAN, GAY, BISEXUAL,
TRANSGENDER, QUEER,
AND HIV-AFFECTED HATE
VIOLENCE IN 2015**

2016 RELEASE EDITION

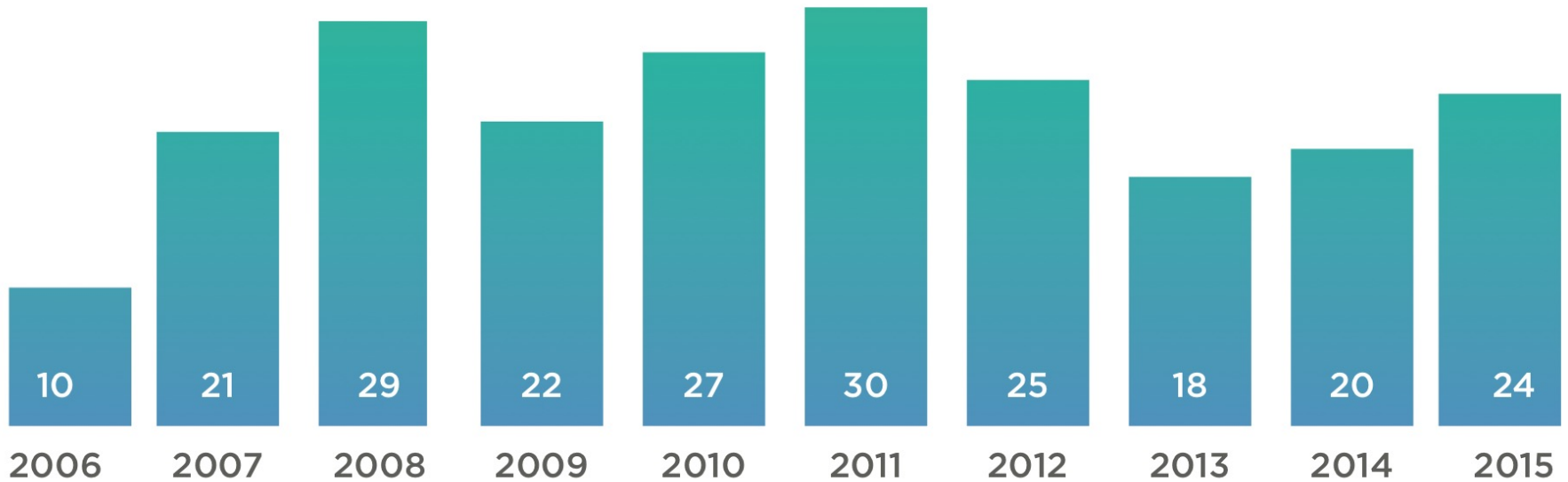
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http://www.avp.org/storage/documents/ncavp_hvreport_2015_final.pdf



“The year 2015 began with unprecedented reports of deadly violence against LGBTQ communities...”

NUMBER OF HATE VIOLENCE HOMICIDES PER YEAR SINCE 2006

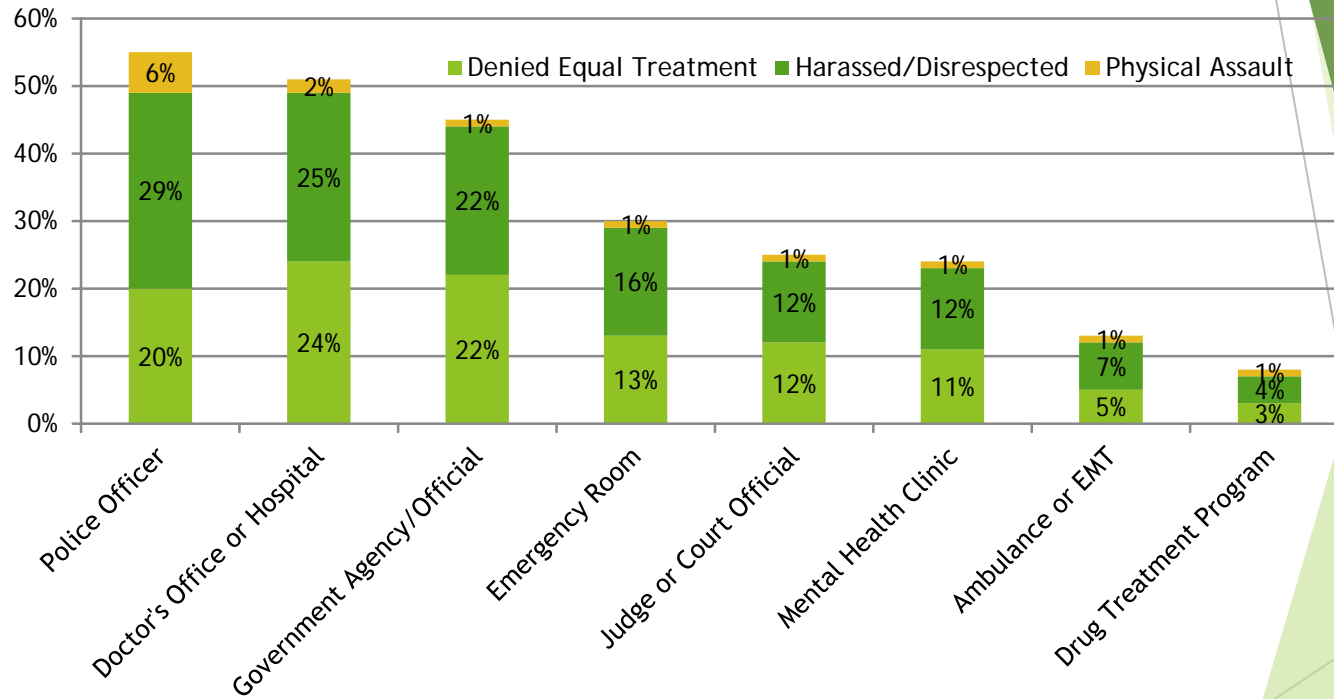


LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER AND HIV-AFFECTED HATE VIOLENCE 2016

18



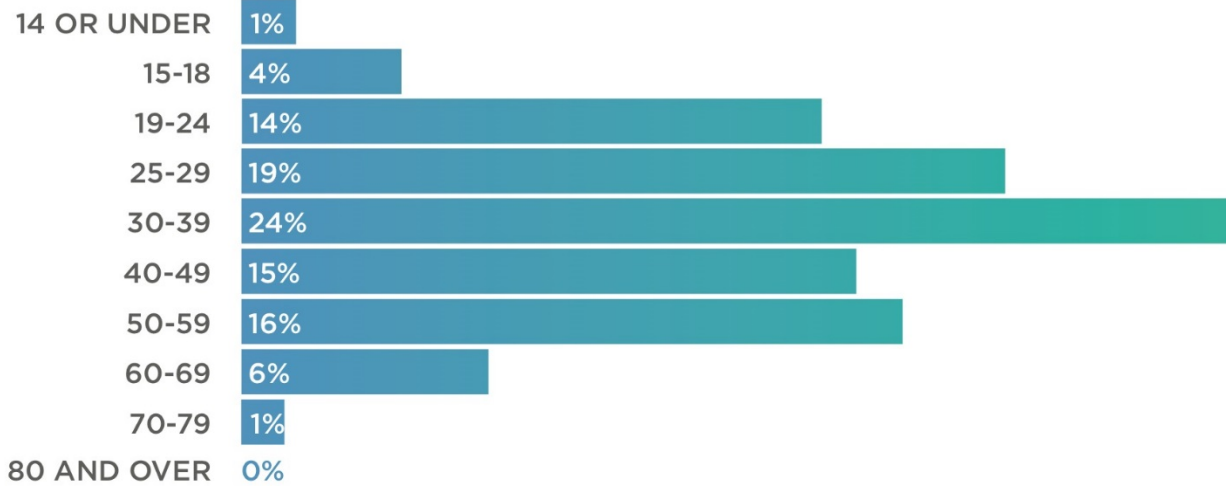
LGBT/HIV+ Discrimination in Public Accommodations





AGE OF SURVIVORS

N=818

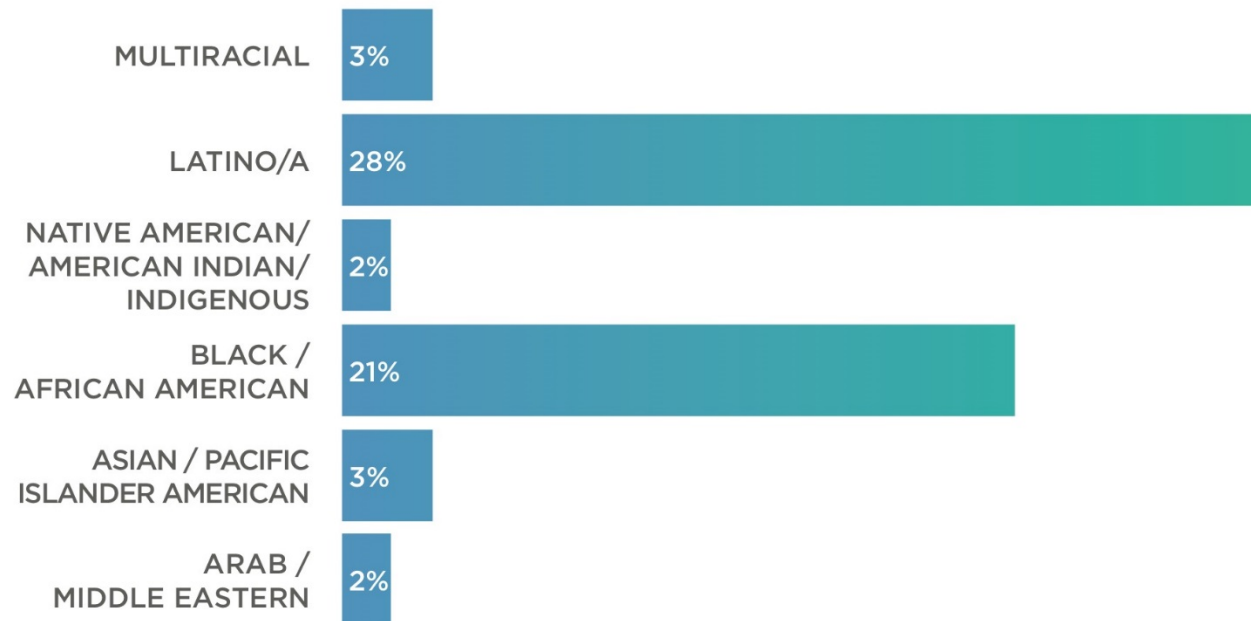




“The survivors identified as...”

RACE AND ETHNICITY OF SURVIVORS OF COLOR

N=931





What they survived:

- ▶ 15% harassment
- ▶ 14% discrimination
- ▶ 12% physical violence
- ▶ 11% threats and intimidation

- ▶ Survivors between the ages 12-24 were 3x more likely to experience hate violence from a relative and 3x more likely to experience violence by an acquaintance compared with older LGBTQ survivors.



HIV/AIDS

MSM account for just 4 percent of the U.S. male population ages 13 and older, the rate of new HIV diagnoses among MSM in the United States is more than 44 times that of other men

Also are at greater risk for:

- ▶ Hepatitis
- ▶ HPV
- ▶ Syphilis

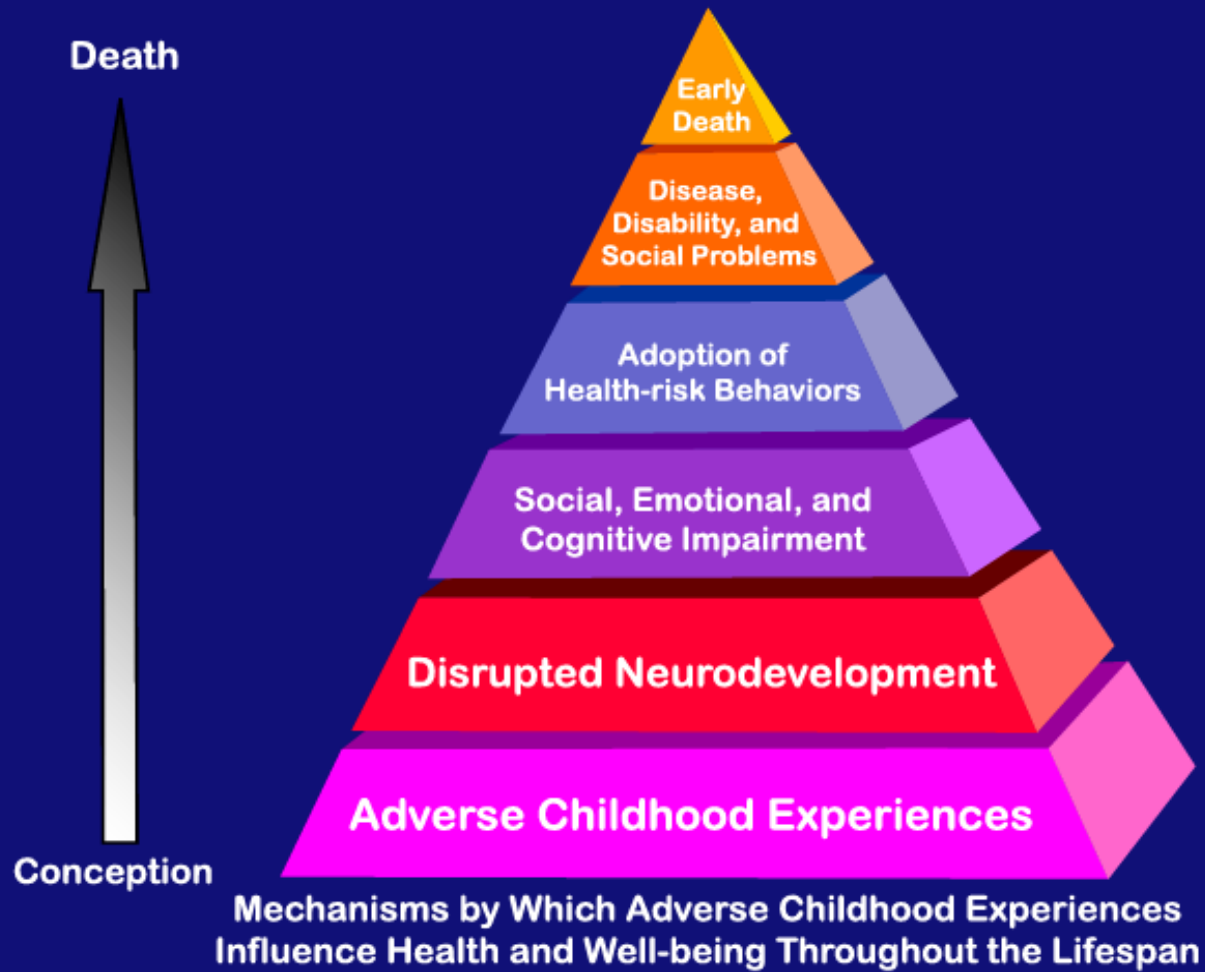


ACE Study

Compares adverse childhood experiences against adult status, on average, a half century later

- ▶ The higher your ACE score the more trauma you have experienced...

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[ACE Study authored by Vincent Felitti MD](#)

Male child with an ACE score of 6 has a 4600% increase in likelihood of later becoming an IV drug user when compared to a male child with an ACE score of 0.

“Might drugs be used for the relief of profound anguish dating back to childhood experiences?
Might it be the best coping device that an individual can find?”

A little historical context...



Between 1981 and 2000,
161,616
individuals infected with HIV were born between 1941-1948



297,068

individuals who will
contract HIV between
1981-2000 were born in
the 1950s.



196, 223

individuals who would
contract HIV between 1981-
2000 were born in the 1960s



History lets us put history in context

Consider the role of:

legal discrimination

Threats of violence

Physical/Sexual Violence

Verbal Abuse

Family/social rejection

Caregiver/medical
discrimination



Substance Abuse and Mental Health Risks

- ▶ It is estimated that between 20-30% of LGBTQ+ people abuse substances, compared to about 9% of the general population.
- ▶ Chemical dependency among LGBTQ+ seniors is often neglected/undetected
- ▶ Several studies suggest that LGBTQ+ people appear to have higher rates of some mental disorders compared than their non-LGBTQ+ peers, although not to the level of a serious pathology.
- ▶ lack of support and acceptance (in self and from others); a lack of resources (mental and medical), and issues of discrimination.
- ▶ In line with the Minority Stress Theory, early victimization on the basis of sexual orientation and/or gender identity/expression has a relationship to later biopsychosocial development.



Drug Use as Coping

Youth

- ▶ Internalized homophobia
- ▶ Experiment & fit in with peers
- ▶ Increase feelings of self-esteem and adequacy
- ▶ Self-medicate for underlying mental health issues
- ▶ Shame about sexual orientation
- ▶ Lack of support network
- ▶ Higher rate of family rejection

Adults

- ▶ High level of stress due to social prejudice and discriminatory laws
- ▶ Centrality of the bar and club scenes as source of socialization and support
- ▶ Less access to quality health care

Why don't they "choose" to get better when we show up to help?

(Damon) Mitchell concluded that this perseveration is nonassociative, that is, if uncoupled from the usual rewards systems, animals seek optimal levels of arousal and this mediates patterns of alternation and perseveration. Because novel stimuli cause arousal, an animal in a state of high arousal will avoid even mildly novel stimuli even if it would reduce exposure to pain.

And...may actively seek out situations to retraumatize themselves:

Some traumatized people remain preoccupied with the trauma at the expense of other life experiences and continue to re-create it in some form for themselves or for others. War veterans may enlist as mercenaries, victims of incest may become prostitutes, and victims of childhood physical abuse seemingly provoke subsequent abuse in foster families or become self-mutilators. Still others identify with the aggressor and do to others what was done to them. Clinically, these people are observed to have a vague sense of apprehension, emptiness, boredom, and anxiety when not involved in activities reminiscent of the trauma.

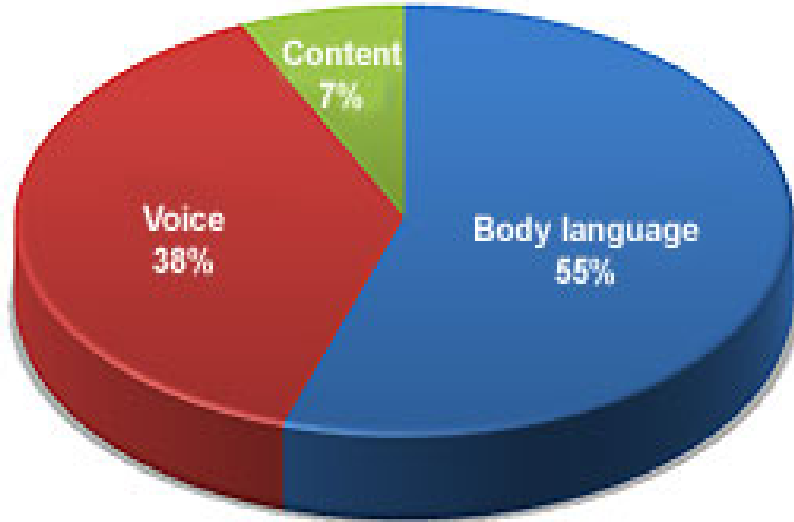
-Bassel van der Kolk, 1997



Elements of Trauma Informed Care:

- ▶ Safety
- ▶ Transparency
- ▶ Peer-Support
- ▶ Collaboration
- ▶ Empowerment/Voice/Choice
- ▶ Cultural Humility

Safety:



Mehrabian Model

Intrinsic:

- Safe in body has to come before safe in mind.
- Safe in mind may require soothing activities for the body
- Safe base: clients need to feel that they can return to/remain in safe place

Tools:

- Safe in communication
- Safe in planning
- Safe in transitions
- Safe in relationships
- Safe in community
- Safe in relapse*



We can all choose our tools: Transparency and Trustworthiness

Create Road Maps During the First Meeting:

BECAUSE THESE CAN BE TRIGGERS:

Time: wait times, interview times,

Process: What happens to/for client and in what order

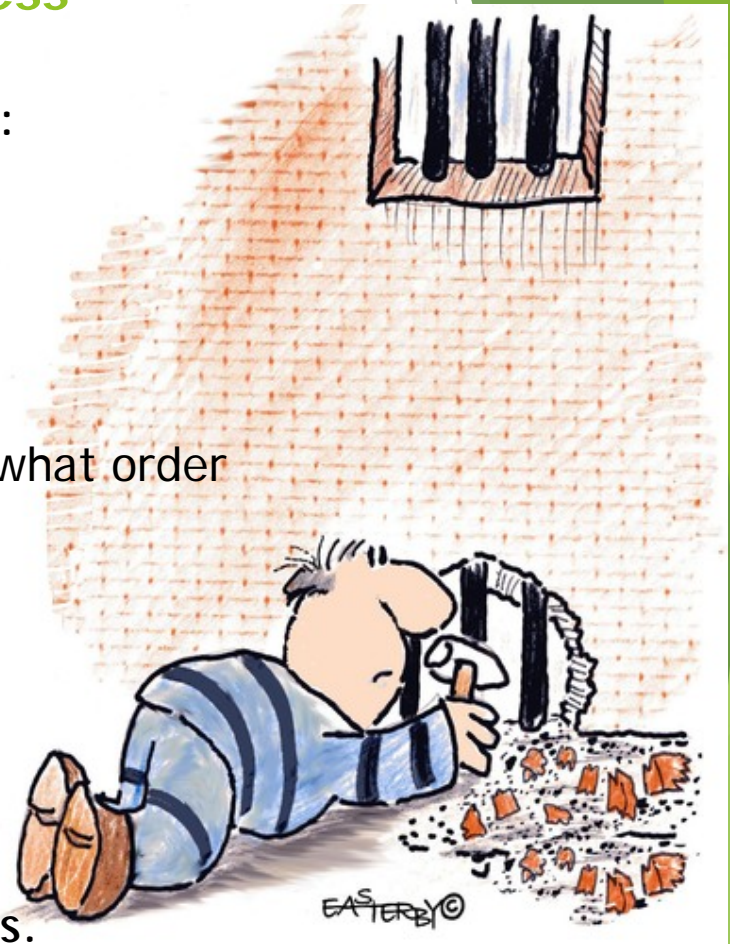
Routine: Agency Changes

Stay Fact Based and Honest.

Keep it simple.

Provide realistic expectations for questions.

Written information should support information, not provide crucial communication.





Transparency in process

Be honest about process:

Prepare clients for potentially uncomfortable encounters

Be honest about which processes are optional and which processes are not.

Stay Fact Based and Honest

Start planning discharge ASAP

- Motivational Interviewing
- Future-based success planning

Provide references for complicated, or multi-step processes



“Your appointment’s been cancelled. You took too long filling out those forms.”



Peer Support/Mutual Support

“We are all broken” or “We’re all here to help.”

Everyone’s situation is unique, but no one is alone

Developing environments where:

- Rules are transparent and enforced
- Power is shared equally
- Everyone can contribute
- No one is forced to contribute
- Contributions are recognized

Language is inclusive

Healthy relationships are modeled.





Collaboration and Mutuality

- Finding value in cooperation
- Empowering patients to be invested
- Seeing the products of shared labor
- Experiencing the fruits of the shared labor
- Acknowledging change from shared activities



Element	Definition
Team-Driven	A multidisciplinary group of healthcare delivery professionals providing care in a coordinated fashion and empowered to work at the top of their professional training.
Population-Focused	The Collaborative Care team is responsible for the provision of care and health outcomes of a defined population of patients
Measurement-Guided	The team uses systematic, disease-specific, patient-reported outcome measures (e.g., symptom rating scales) to drive clinical decision-making.
Evidence-Based	The team adapts scientifically proven treatments within an individual clinical context to achieve improved health outcomes.

<https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-trained/about-collaborative-care>



Empowerment/Voice/Choice

Difference between power and authority:

Empowerment starts with good boundaries.

Providing space and safety for expression:

The goal is for the client to listen to and understand the information and then craft his/her/their own choices and then choose among those choices.

Knowledge+Action=real choice, real power



Cultural Humility:

“Language is the first weapon drawn in a conflict.”

The goal is to choose language that promotes consent and limits blaming. When it does happen
It is a validation of experience;

Provides stabilizes victim/survivor equilibrium;

And provides opportunity for survivor/victim to start piecing together what happened: Understand in retrospect what happened.

Language:

Use active voice. (references from Jackson Katz). Watch how Jack disappears:

Jack beat Mary	Active verb
Mary was beaten by Jack	Passive verb: Mary is now primary
Mary was beaten	Jack is gone
Mary is a beaten woman	Jack, the perpetrator, has disappeared



Self-Care



“The body is an instrument, and unlike the mind is blessed with a permanent limitation. Thoughts can soar and emotions can roar, but the feet are subject to laws that keep them on the ground. The body lives in the present, doing only one thing at a time. It is a faithful companion in the search for presence when it is given more attention and respect, when one tries to listen to its messages, even though they are expressed in a language foreign to the mind.”

--Patty de Llosa “Befriending the body in Parabola Magazine 2018



Boundaries

- Changing see-smell-hear-touch leaving work
- A place to “dump” work stories before coming home
- Narratives for non-work people
- Investigating roles outside of work that mimic the stress at work

Body

- Learning to pay attention to triggers
- Coping mechanisms for triggers
- Healthy practices to provide alternatives to triggers

Practice

- Rituals of transition
- Recognizing the rhythms/seasons of work stress
- Work on your own history with love and compassion

Community

- Find your helpers
- Work toward transparency and reciprocity
- Focus on why the relationship is important (to avoid transference)
- Investigate power dynamics



Developing a Tool-Box of Care

Everyday Stress

Constant
throughout
the year

Supports good
boundaries
and healthy
activities

Seasonal/Episodic stress

Acknowledges
seasons of
stress

Find extra
supports for
particularly
difficult
experiences

Acute stress

Promotes success in the
moment

Include a plan to process
after the event is over

Thank You!



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