Trauma Informed Care: Housing First Through a Trauma Lens

April 11, 2018 Housing First Partners Conference

Trauma-Informed Care

- What do things like domestic violence, rape, and gang violence have to do with mental illness, substance use and homelessness?

Why learn about trauma-*informed* care?

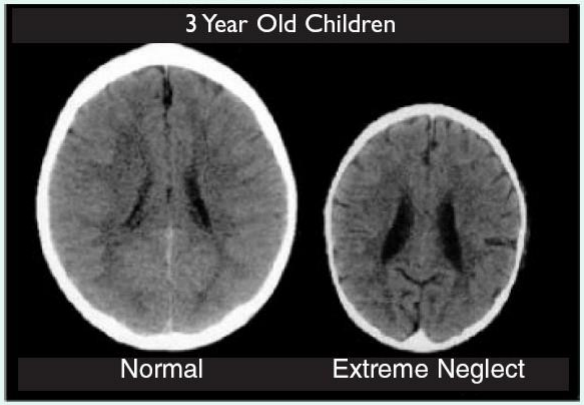
- Staff will develop their skills.
- Our services will be more respectful.
- Participants will feel more respected.
- Participants will be more willing to trust on a deeper level, and develop new skills and habits.

Trauma-Informed vs. Trauma-Specific Treatment

- Trauma-***informed*** treatment is not designed to treat symptoms or syndromes related to trauma. It is **sensitive** to trauma-related issues present in consumers.
- Trauma-***specific*** treatment is designed to treat the actual effects of sexual, physical or psychological abuse and trauma.

What is trauma?

Figure 4.2: Differences in brain development following sensory neglect



This figure compares the brain of a normal 3-year-old child (the image on the left) with the brain of a 3-year-old who has suffered severe environmental sensory-deprivation neglect (the image on the right). The child who has suffered neglect has a significantly smaller brain and has enlarged ventricles and cortical atrophy.[47]

What is trauma?

- The APA defines a ‘traumatic event’ as one in which a person experiences, witnesses, or is confronted with actual or threatened death, serious injury, or threat to the physical integrity of oneself or others.

What is trauma?

Esther Giller, the President of the Sidran Traumatic Stress Institute, offers the following:

- "We all use the word 'trauma' in everyday language to mean a highly stressful event. But the key to understanding traumatic events is that it refers to ***extreme stress that overwhelms a person's ability to cope***. There are no clear divisions between stress, trauma, and adaptation. Although I am writing about psychological trauma, it is also important to keep in mind that ***stress reactions are clearly physiological as well***. Different experts in the field define psychological trauma in different ways. What I want to emphasize is that it is an individual's ***subjective experience*** that determines whether an event is or is not traumatic."

What is trauma?

- "Psychological trauma is the **unique, individual experience** of **an event** **or** **enduring conditions**, in which:

1. The individual is emotionally overwhelmed, *or*
2. The individual experiences (subjectively) a threat to life, bodily integrity, or sanity."

What is trauma?

In his book Coping With Trauma (1995), Jon Allen states:
"…it is the subjective experience of the objective events that constitutes trauma…the more you believe you are endangered, the more traumatized you are…psychologically, the bottom line of trauma is overwhelming emotion and feeling of utter helplessness…in other words, trauma is defined by the experience of the survivor."

In short, trauma is…

- The precipitating event(s) – what ***HAPPENED***
- The ensuing experience and aftermath of the event . . . How a person ***FEELS*** about the event and how it ***EFFECTS*** their sense of self, the world, and other people.

In fact, trauma is an important factor in the lives of virtually all people diagnosed with mental illness.

- Trauma increases the risk of developing a psychiatric illness. It can be a precipitating factor, or a direct cause of the changes in the brain that result in a specific illness.
- Having a mental illness increases the risk of being traumatized. For instance, one study revealed that people with serious mental illnesses living in Chicago are four times more likely to be victims of violent crimes than the general population.
- The mental health system itself is traumatizing. Consumers of mental health services have often been traumatized by the system, many severely in circumstances involving seclusion, restraint, assault, involuntary commitment, forced medication and forced ECT. Many have been retraumatized by a mental health system that has ignored trauma suffered both outside the system and within it.

PTSD and people with serious mental illness

- PTSD occurs at a rate of about 8% in the general population
- A 1998 study by Kim Mueser et al of mental health consumers in Maryland and New Hampshire found that 48% of the consumers interviewed met the criteria for PTSD while only 2% had this diagnosis in their records.
- In similar studies in the US, between 23% and 48% of consumers met the criteria for PTSD.

What does this mean?

- The mental health system ignores the trauma experienced by the people served.
- Those responsible for diagnosing are not asking the right questions.

However,

- There is no ONE diagnosis that encompasses all participants with trauma histories; rather people carrying ANY diagnosis may be trauma survivors and survivors often carry MANY diagnoses.

Not everyone who experiences trauma will go on to develop PTSD, but trauma can still effect many aspects of their lives.

- Certain behaviors that we might be tempted to attribute to a participant's mental illness might actually be survival techniques, responding to traumatic experiences.
- A participant receiving job services secured a job that they were well suited for and excited about. On their first day, they didn't show up. When asked why, they said that they would have to go under a viaduct in order to go from home to the workplace, and that they had once been assaulted when walking under a viaduct, so couldn't bring themselves to go.

Continued…

From a participant:
"I have a lot of fear because I was raped by a friend of mine. People have to believe that they can face the fear itself. Fear is a big thing by itself because you have a lot of things coming at you at once. You are trying to juggle everything at once. You have to stop and think what is real and not in your life."

Why do *you* need to know about trauma?

- **60 – 70%** of the general population has experienced at least one traumatic event in their lifetime.
- Estimates suggest that **80-95%** of mental health consumers have been exposed to at least one traumatic event.
- **34 – 53%** of consumers report childhood sexual abuse.
- **25 – 35%** of persons with serious mental illness report **repeated** traumatization.

Prevalence, cont.

- Post Traumatic Stress Disorder (PTSD)
  - 10.4% women
  - 5% men
- Lifetime prevalence of PTSD in persons with Severe Mental Illness: 29-43%
- PTSD has been diagnosed in 24-85% of persons with alcohol or drug use disorders.
- An estimated 46% of women with co-occurring SMI and substance use disorders experience PTSD.

90-95% of homeless women who have mental illnesses have experienced repeated traumatization, and many probably have PTSD.

In fact, trauma has been and *is* an important factor in the lives of virtually *all* people diagnosed with mental illnesses.

Trauma increases the risk of developing all kinds of psychiatric illnesses. It can be a precipitating factor (one of the 'stressors' of the stress/vulnerability model), or a direct cause of changes in the brain that result in a specific illness: Post Traumatic Stress Disorder (PTSD).

Behaviors/symptoms that **may** indicate a history of trauma:

- Compulsive sexual behaviors or complete avoidance of sexual relations
- Catastrophization and dire world view
- Hypervigilance and paranoia
- Chronic substance use, especially as self-medication
- Sadomasochistic fantasies
- History of homelessness, incarceration, and frequent crises or inpatient psychiatric hospitalizations
- Extreme sensitivity and insecurity in relationships with others

Behaviors/symptoms that **may** indicate a history of trauma (continued):

- Self-injurious behaviors
- Low energy or chronic fatigue
- History of chronic STIs
- Frequent high-risk sexual encounters
- Extreme and volatile affect: i.e. depression and/or melancholy or explosivity and/or rage
- Dissociative episodes
- Isolation and withdrawal
- Excessive neediness or dependence
- Decisional impairment
- Extreme distrust or overtrusting
- Sleep difficulties

You have no doubt seen many of these symptoms . . .

- These symptoms are not PROOF that a person experienced trauma, however . . .
- It is safe to assume that since such a high percentage of people seen at your agency HAVE experienced trauma . . .
  - We should treat all participants "as if" they have a trauma history.

Questions to consider regarding individual participants:

- Is there anything the participant does or feels that indicates they might have a trauma history?
- Has the participant previously had any overwhelming/ traumatic experiences?
- What do you know about this participant's trauma history?
- If you are aware that this participant has a trauma history, how do you see this play out in their life?

Questions…

- Since you have been working with the participant, have they experienced a traumatic event?
- Has the participant ever opened up to you about the trauma they've experienced? Are they able to talk about those experiences?
- Does the participant become overwhelmed or upset when talking about past trauma?
- How do you feel when a participant talks about their trauma history with you?
- How does it make you feel knowing about a participants trauma history?

Questions…

- Does the participant have adequate resources to help them address their trauma?
- Are there current threats to the participant's safety or well being?
- Is the participant involved in safe and trusting relationships?
- How do you see the participant's current interpersonal relationships being affected by their trauma history?
- What do you see in the participant's daily life that may be connected to their trauma history?

Questions…

- What positive and healthy coping skills would help the participant to better manage their emotions and crises? What positive and healthy coping skills does the participant already use?
- How do you think trauma has impacted the way the participant thinks about their future and goals?
- What are ways you see the participant as overcoming their trauma history? In what ways are they resilient? How can you frame 'unhealthy' or even overtly harmful behaviors as evidence of resilience and strength (as ways that the participant has survived?)

Consumers of mental health services have often been traumatized by the system – in circumstances involving seclusion, restraint, assault, involuntary commitment, **forced** medication, and **forced** electroconvulsive therapy. Many have also been re-traumatized by a mental health system that has ignored trauma suffered both outside the system and within it.

The mental health system itself is often traumatizing.

All of these disorders can have co-morbidity with trauma:

- Affective disorders
- Psychotic disorders
- Personality disorders
- Eating disorders
- Substance use disorders
- Dissociative disorders
- ADHD/impulse control disorders
- Other anxiety disorders

There is **no** ***ONE*** diagnosis
that encompasses all participants
with trauma histories;
rather people carrying ***ANY***
diagnosis may be trauma survivors
and survivors often carry ***MANY***
diagnoses.

There are principles to help you respond to people with trauma effectively

These five principles will help you to maintain a trauma-informed stance as a clinician:

- **Accept** the participant's experience as **true** (and that the trauma was not the participant's fault).
- **Understand** that behavior may be a technique the participant uses to **survive** past or present trauma.
- **Acknowledge** that trauma can be both **a cause and a result** of a participant's mental health diagnosis.
- **Respect** **choices** in all ways possible (including the participant's right to share or not share his or her traumatic experience); offer choices if necessary (participants often do not realize they have choices). Respect boundaries.
- **Remember** the real question is not "What is wrong with you?" but **"What happened to you?"**

Remember to *ask* permission

For instance, **ask…**

→ If you can come in to their room/apt.

→ Where you should sit

→ If it's OK to touch the person (e.g., "Is it OK if I shake your hand?")

→ Whether the person wants the door open or closed

→ ***Even whether or not to talk about trauma in the past, or how much detail will be talked about***

Tips on a trauma-informed initial interview: adding the trauma "lens"

- Assume a trauma history.
- View symptoms as possible adaptations or survival techniques for trauma.
- Pay attention to yourself. Try to stay ***neutral*** and interested in your facial expression and tone of voice.
- Co-create safety based on the ***participant's*** definition.
- Respect boundaries.
- Express gratitude when a participant shares a story.
- Try to end the meeting on a positive note, i.e., focus on strengths and willingness to get better.

Tips on providing trauma-informed services

Do . . .

- Ask about trauma
- Be neutral, but supportive
- Validate what you hear
- Be OK with a participant's strong emotions or complete numbness
- Follow the person's lead and don't probe too much
- Offer continual reassurance of current safety and ability to cope
- Be prepared with hotlines and referrals
- Access support and supervision for yourself
- Manage boundaries appropriately:
  - Keep a regular schedule with the person. Devoting excessive amounts of time to the person will not make them heal faster.
  - Avoid giving out your cell phone number.
  - Avoid special favors.
  - Avoid feeling sorry for the person.

Tips on providing trauma-informed services (cont.)

Try to avoid . . .

- Allowing your own ambivalence or fear to inhibit your responsiveness
- Persisting with questions when the participant is reluctant to talk
- Over-diagnosing or labeling what you are seeing
- Engaging in treatment activities for which you are not qualified
- Denying your own feelings or reactions
- Speculating about what happened to the person
- Expecting a linear process of recovery
- Over-pathologizing coping behaviors
- Rigidity about rules and regulations

Treatment for trauma

- Trauma support groups
  - People who have experienced trauma go to groups with others who have similar experiences and provide support to other group members.
- Cognitive Behavioral Therapy (CBT and various similar types of therapy)
  - People learn to think and feel differently about the trauma through using self reflection and intentional ways to change their moods and thinking.
- Eye Movement Desensitization and Reprocessing
  - A newer therapy developed by a trauma therapist who noticed that when people think about a traumatic event while changing the movement in their eyes, their anxiety decreased. Eye movement and regular exposure type therapy is combined to help people manage traumatic memories more effectively.
- Exposure therapy
  - Under the guidance of a therapist, people are gradually exposed to the thing or event that is causing them anxiety. This might involve thinking about the event or revisiting things the person associates with the event.

Treatment for trauma

- **Pharmacotherapy**
  - SSRIs for depression and anxiety
  - Benzodiazepines for panic
  - Low dose antipsychotics for dissociation and brief psychotic symptoms
  - Sleep aids
  - Mood stabilizers for emotional dysregulation

Alternative Treatments*

Yoga
Meditation
Mindfulness
Bodywork
Breath work
Acupuncture
Aromatherapy
Hypnotherapy

*Sometimes these services can be gotten for free or reduced fees.

Helping the helper

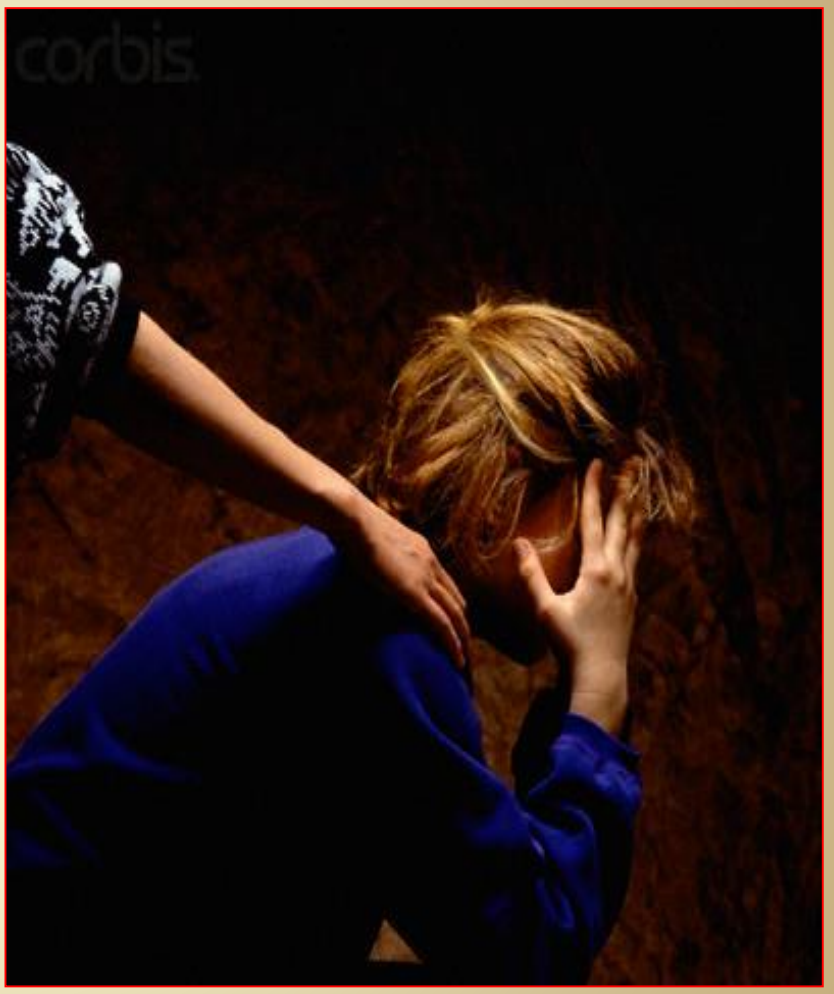
- Sometimes we are bothered by what a participant tells us. We experience secondary trauma or vicarious trauma by hearing what a participant has experienced.
- Pay attention to these feelings! Seek support!
  - Your co-workers
  - Your supervisor
  - Your Employee Assistance Program
  - Family and friends, if they are aware of the type of work we do. If not, you may not get the support you need.

It Starts With You…….

- How safe does the participant feel in his/her work with you (your team)? (both emotionally and physically)
- Does the participant perceive you (the team) and your services to be trustworthy? (i.e., consistent, clear, appropriate boundary management)
- Is the participant given adequate choice and control re: services?
- Are services provided in a collaborative manner?

- Is participant empowered in his/her treatment relationship with you?

Trauma-informed services and trauma-informed care involve honoring a person's history and being sensitive to not re-traumatizing the person.



Bringing Trauma-Informed Services To An Agency: Initial Steps

-Find 'champions'
-Form a committee
-Compile resources
-Initiate awareness
-Take an agency 'temperature'
-Initiate trauma-informed interventions
-Provide agency-wide training
-Provide concrete tools
-Provide clinical supervision
-Provide follow-up
-Train all new staff
-Add to all intake paperwork

Bringing Trauma-Informed Services To An Agency: Challenges

-funding
-time
-resources
-turnover
-expertise

Vignette #1

One of your participants periodically engages in self-injurious behaviors. Some of your team perceives this as 'attention seeking' and believes that the best intervention is to call 911, no matter the severity of the cut(s). What might you suggest using a trauma-informed approach? Using a Harm Reduction approach?

Vignette #2

During an inspection, one of your staff finds that a new participant's door can barely open enough to enter due to the client's excessive over-acquiring. Your staff reports that the participant's room is 'disgusting' and that 'they just need to throw that stuff away'. How might you respond using a trauma-focused approach? A harm reduction approach?

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