Trauma-Informed & Responsive Services for Health Care and Human Service Work

Yodit Betru, DSW, LCSW, MSW

University of Pittsburgh
School of Social Work

Agenda

- Introduction
- Brief review of stress and trauma reactions
- Relational/structural issues that come up when clients attempt to access health and human services
- Trauma informed responses for health care providers
  - Trauma informed primary care as a model
- Self-care for workers

What is stress and what rises to the level of trauma exposure?

- Stress is normative, adaptive, and helpful
- We have biological and automatic responses to stress that help us regulate and survive
- Typical stress responses, fight, flight, freeze and appease
- We need periods of rest to help process and digest stress
- Unrelenting chronic exposure alters our physiology

Stress turns into trauma

- Exposure to death (threatened or actual), serious injury, or sexual violence
- Witnessing, in person (not on TV)
- Indirectly learning that close relative or friend was exposed to traumas (must be violent)
- Repeated or indirect exposure to trauma in the course of professional duty
- 60% of adults report one ACE, 9% 5 or more ACES (CDC 2009)

Oppression Trauma

- Exposure criterion for PTSD DX is limited to interpersonal or physical stressors
  - Not institutional, systemic, or psychological – everyday devaluation that leads to early death
- Forms of oppression
  - Racism
    - Discrimination & PTSD
  - Sexism
    - Gender based oppression & PTSD
  - Heterosexism
    - Hate crime and heterosexual discrimination & PTSD
    - Gender non-conformity may predict abuse and PTSD

Marginalized/minoritized experiences/identities increase disparity to access and care

- People on the margins may come into care settings activated
- Health care environments can exclude or erase the existence of certain groups by not including the identity or category on forms, staff, and physical space.
- Cumulative impact of trauma, discrimination, micro-aggression, and minority stress exacerbate symptoms, increase avoidance, and decrease help seeking behaviors

Meaning making

- Trauma impacts the meaning making structures
- Why did this happen? What was God thinking? Why me/us and why this time?
- Shatters our assumption that the world is good and safe
- Can create enduring pattern of relating where people have a trauma reaction to all stressors. **This is often the case when clients come in to have sensitive conversations in healthcare settings**

Working with survivors who are attempting to access health and human services

- Domains that people have expressed that they need help in are below: Have this in mind as you engage with people.
  - Where can they get services?
  - How do they navigate fragmented services with complicated instructions?
  - How do they manage a hectic schedule?
  - How do they manage burnout and stress?

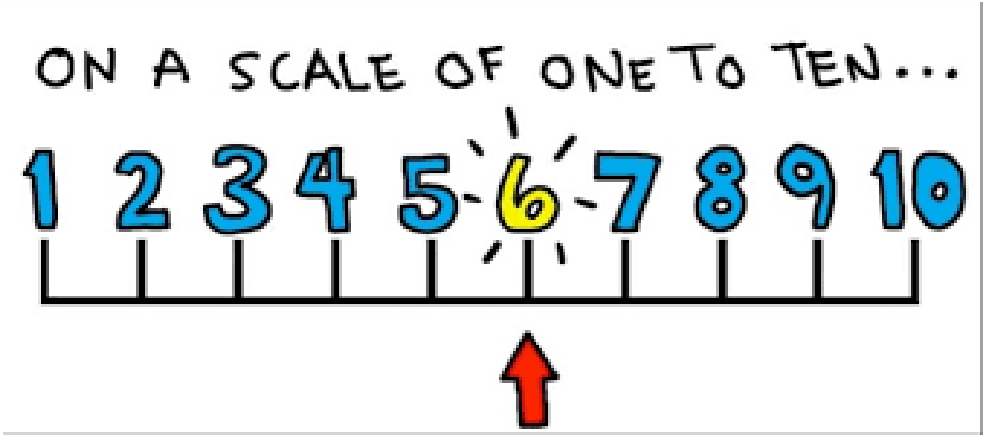
How do you address these things in trauma-informed sensitive manner

- Is there a universal trauma screener for your work? If not, get one.
  - Why is this person, presenting with this issue, in this way, at this time?
  - Reference it in your meeting with them and be aware of their stress reaction throughout the session
- Ask the client about the past attempt with the issue
  - Level setting
- Review resources strengths, and cultural/racial considerations in meeting the need
  - Who from the community, your family, or friends has tried to help you with this matter in the past? What was helpful? How much help did they give you?
- Discuss the internal and external barriers to meeting the need
  - Can you tell me about what things stand in the way of you getting this need?

How accessible are your services?

- Approachable?
- Accepting?
  - Professional values and norms
- Accommodating?
  - Time, geography, modes of provision of service
- Affordable?
- Fit?

Determine your stance, use theory to inform your engagement



- On a scale of 1-10
  - How ready they are to address the goal
  - How confident are they to address the goal
- Based on the answers above your stance can be the following
  - Nurturing- Giving information but not much advice
  - Socratic- Empathic & explorative questions
  - Coach- Build a game plan
  - Consultant- Expert advice

General guides for working with survivors

- Normalize their fear responses and expect it to be the baseline interaction style
- Do not expect them to be grateful or thankful for your services at the time-of-service delivery
- Be predictable, give choice and autonomy when you can, and thank them or acknowledge their strengths
- Connect them to individual and communal resources
  - It’s your responsibility to be culturally informed

What you can do for crisis response

- Be careful how much detail you ask for
  - Debriefing can be activating. If it is part of the job, tell them in advance the reactions they may have from sharing information with you.
- Share the range of reactions they might have.
- Ask if they have had this kind of reaction before.
- What have they done to manage their reactions before that was helpful?
- If they have not had this type of reaction, who or what resources are available to them?

Table 1. A model for trauma-informed primary care

Key Elements	TIC	TIPC
Recognition	Recognition of trauma history	Screening and trauma recognition: In a calm and empathic manner, ask about exposure to trauma. Acknowledge that disclosure is difficult and that the patient may disclose when comfortable.
Realization	Trauma influences individuals, their environment, social network, and treatment	Understanding the health effects of trauma: Empower the patient by education about the effects of trauma on health and health-related behaviors.
Response	Patient-centered and controlled care	Patient-centered communication and care: Patients are in control of their care and decisions about their health.
Respect	Respect for emotional safety; avoiding re-traumatization	Emphasize emotional safety and avoid triggers: Identify examinations and procedures that may result in anxiety, flashbacks, or other re-traumatization and create care that is acceptable to the patient.
Resilience	Base care approach on individual strengths	Knowledge of helpful treatment for trauma patients: Recognize individual strengths in managing health. Encourage resilience by focusing on positive aspects of patients' lives (what is going well) to reduce physical and psychological symptoms and improve disease management.

Note: TIC = trauma-informed care; TIPC = trauma-informed primary care.

JOURNAL OF THE AMERICAN ASSOCIATION OF NURSE PRACTITIONERS

What brings you to this work?

- Why are people drawn to working with trauma survivors and injured systems?
- What is drawing you to this work?
- How will you hold yourself while caring for others?
- What is the cost and what is the gain of doing this intense work?
- How will you build in buffers for the trauma exposure?

Secondary Stress/Exposure, Vicarious Trauma: Occupational Hazard

- Can workers meet criteria for PTSD by working with survivors?
- Reported symptoms
  - 70% report at least one distress symptom
- Most cited symptom
  - Intrusive thoughts
- Other responses
  - Psychological distress
  - Physiological arousal
- Rare but it occurs—dreams, reliving the incident
- Long-term manifestation as burnout
  - Depersonalization
  - Negative world view

Working with survivors

- You must develop your own meaning making system to contain the pain and horror you will bear witness to
- What will you do with what has been trusted to you?
- Do you become rigid?
- Do you struggle with boundaries?
- Are you sharing the pain or soaking it all up?

University of Pittsburgh
School of Social Work

Worker resilience

- Understand impact of working with trauma survivors
- Understand factors that increase job satisfaction
  - Training
  - Improved coping strategies
  - Supportive work environment

What are the benefits?

- Increased job satisfaction
- Longer retention at work
- Increased sense of connection to self and others
- Work with trauma survivors starts with self-awareness and self care
- Create a plan of self care

Treat yourself

- Don’t confuse consumption with self-care
  - Treat yourself
  - https://www.youtube.com/watch?v=gSjM5B3QNlw
- Rest and digest
- Sliming

Create a Personal Self-Care Plan

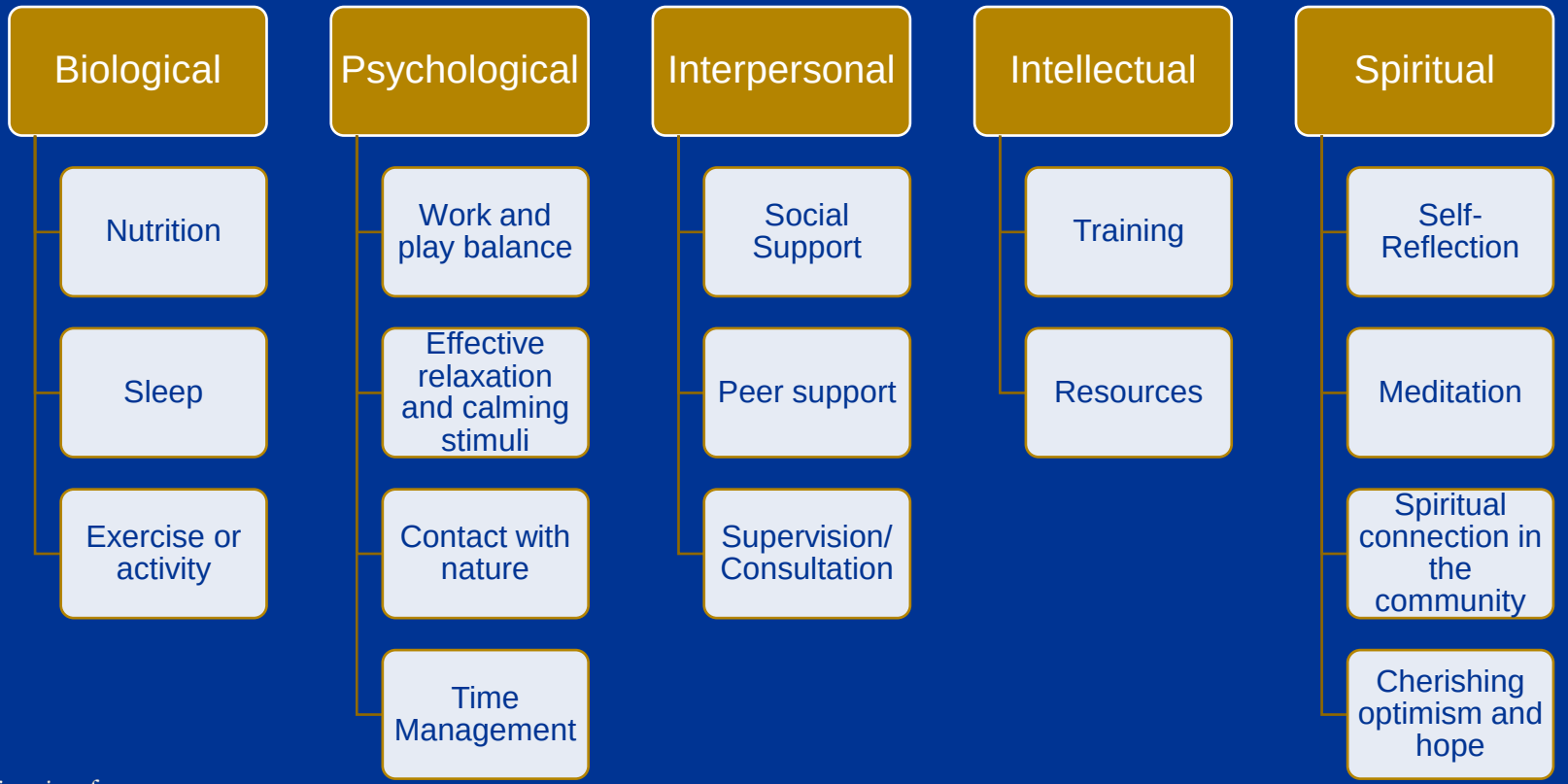
Create self-care plan

- Detect work stress
- Link it to consequences
- Identify and correct organizational culture to promote growth
- Develop self care plan
- Monitor the plan
- Get help if the care plan does not sufficiently promote resilience

Tool to help screen and monitor care plan

- Secondary Traumatic Stress Scale

Life Domain: What is meaningful and important?



Planned Care for Self

1. Select one goal for a category: Be specific about your goal
2. Review past attempt to meet goal and analyze what was helpful and what was stumbling block
3. Determine how goal will be implemented
4. Share the plan
5. Monitor the plan
6. Notice and appreciate changes

SECONDARY TRAUMATIC STRESS SCALE

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the past **seven (7) days** by circling the corresponding number next to the statement.

NOTE: *"Client" is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work such as consumer, patient, recipient, etc.*

	Never	Rarely	Occasionally	Often	Very Often
1. I felt emotionally numb	1	2	3	4	5
2. My heart started pounding when I thought about my work with clients	1	2	3	4	5
3. It seemed as if I was reliving the trauma(s) experienced by my client(s)	1	2	3	4	5
4. I had trouble sleeping	1	2	3	4	5
5. I felt discouraged about the future	1	2	3	4	5
6. Reminders of my work with clients upset me	1	2	3	4	5
7. I had little interest in being around others	1	2	3	4	5
8. I felt jumpy	1	2	3	4	5
9. I was less active than usual	1	2	3	4	5
10. I thought about my work with clients when I didn't intend to	1	2	3	4	5
11. I had trouble concentrating	1	2	3	4	5
12. I avoided people, places, or things that reminded me of my work with clients	1	2	3	4	5
13. I had disturbing dreams about my work with clients	1	2	3	4	5
14. I wanted to avoid working with some clients	1	2	3	4	5
15. I was easily annoyed	1	2	3	4	5
16. I expected something bad to happen	1	2	3	4	5
17. I noticed gaps in my memory about client sessions	1	2	3	4	5

Intrusion Subscale (add items 2, 3, 6, 10, 13)	Intrusion Score _____
Avoidance Subscale (add items 1, 5, 7, 9, 12, 14, 17)	Avoidance Score _____
Arousal Subscale (add items 4, 8, 11, 15, 16)	Arousal Score _____
TOTAL (add Intrusion, Arousal, and Avoidance Scores)	Total Score _____

Citation: Bride, B.E., Robinson, M.R., Yegidis, B., & Figley, C.R. (2004). Development and validation of the Secondary Traumatic Stress Scale. *Research on Social Work Practice, 14*, 27-35.

References

- Dansese, A. & McEwen. (2012). Adverse child hood experiences, allostasis, allostatic load, and age related disease. *Physiology & Behavior*, 106, 23-39.
- Fast, E. & Collin-Vezina, D. (2010). Historical trauma, race based trauma, and resilience of indigenous peoples: A literature review. *First Peoples Child & Family Review*, 5 (1), 126-136.
- Harris, M. & Fallot, R. (2001). Envisioning a trauma informed service system: A vital paradigm shift. New Directions for Mental Health Services 89, 3 -22.
- Holmes, S. Facemire, V., & DaFonseca, (2016). Expanding criterion, A for posttraumatic stress disorder: Considering the deleterious impact of oppression. *American Psychological Association,* 22 (4), 314-321.
- Ko, S., Ford, J., Kassam, A., Berkowitz, S., Wilson, C. & Wong, M. (2008). Creating trauma informed systems: Child Welfare, Education, First Responses, Healthcare, and Juvenile Justice. *Professional Psychology: Research and Practice,* 396-404.

References

- Perry, B. (2001). Neuroacheology of childhood maltreatment: The neurodevelopment costs of adverse childhood events. In Franey, K., Geffer, R. & Falconer, R (Eds). *The cost of maltreatment: Who pays? We all do* (15-37). Family Violence and Sexual Assault Institute, San Diego.
- Roberts, A. L., Rosario, M., Corliss, H., Koenen, K. C., & Austin, S. B. (2012). Childhood gender non-conformity: A risk indicator for childhood abuse and posttraumatic stress in youth. *Pediatrics*, 129, 410-417.
- Shonkoff, J., Garner, A. The Committee on psychosocial aspects of child and family health (2011). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics,* 129 (1). DOI: 10.1542/peds.2011-2663 originally published online December 26, 2011
- Tedaschi, R. & Calhun, L. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry,* 15 (10), 1-18.

References

- Wagman, M., Geiger, J., Shockely, C., & Segal. E. (2015). The role of empathy in burnout, compassion satisfaction, and secondary stress among social workers. *Social Work,* 60 (3), 201-209.
- Woodward, C., & Joseph, S. (2003). Positive change processes and posttraumatic growth in people who have experienced childhood abuse: Understanding vehicles of change. *Psychology and Psychotherapy: Theory, Research and Practice, 76*, 267-283.

Thank you!

Who will develop PTSD?

Ecological model—mix of vulnerabilities and strengths

- Micro
  - Genetics
  - Hardiness
  - Self-enhancement
  - Laughter
- Meso
  - Family
  - Social supports
- Macro
  - Community supports

PTSD

- Must have exposure
- All symptoms start or worsen after trauma
- Removed fear response – no need to have fear, helplessness or horror reaction
- **4 clusters**: **Intrusion** (re-experiencing), **avoidance**, **negative alterations in mood**, marked **alteration in arousal and reactivity** associated with traumatic event (hypervigilance, sleep disturbance, concentration problems)
- Separate criteria for children 6 years or younger
- More than one month of symptoms
- Significant distress or functional impairment

Treatment for trauma

- Many evidence-based treatments
  - Narrative exposure therapy—looks at the social context of the traumas and understands that trauma is not single event; well suited for survivors
- Range from short-term symptom relief to long-term working on trauma narrative
- Essential components of trauma treatment
  - Trauma screening
  - Psychoeducation
  - Review traumatic event using developmentally and culturally/ethnically/racially appropriate techniques
  - Emotional regulation
  - Problem solving skills