TRAUMA AND TRAUMA INFORMED CARE

'the core experiences of psychological trauma are *disempowerment* and *disconnection* from others.

Recovery, therefore, is based on the *empowerment* of survivors and the creation of *new connections*'

Dr Louise Martin, Dr Amy Brown and Dr Harry Rowe (April 2022)

AIMS – WHAT ARE YOU HOPING FOR FROM TODAY?

- Understand what trauma is
- Understand how trauma affects people
- Know what a diagnosis of PTSD, cPTSD and BPD means
- Understand how trauma can affect peoples' relationship with services
- Know what trauma informed care means
- Springboard for discussion about our service /practice
- Housekeeping / break - recording

LOOK AFTER
YOURSELF

WHAT IS TRAUMA AND HOW COMMON IS IT

- SAMHSA describes individual trauma as resulting from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.“

- 75% people in substance use services report trauma in their lives

DIAGNOSES ASSOCIATED WITH TRAUMA

- Anxiety
- Chronic pain
- Psychotic illness
- Bipolar Disorder
- Depression

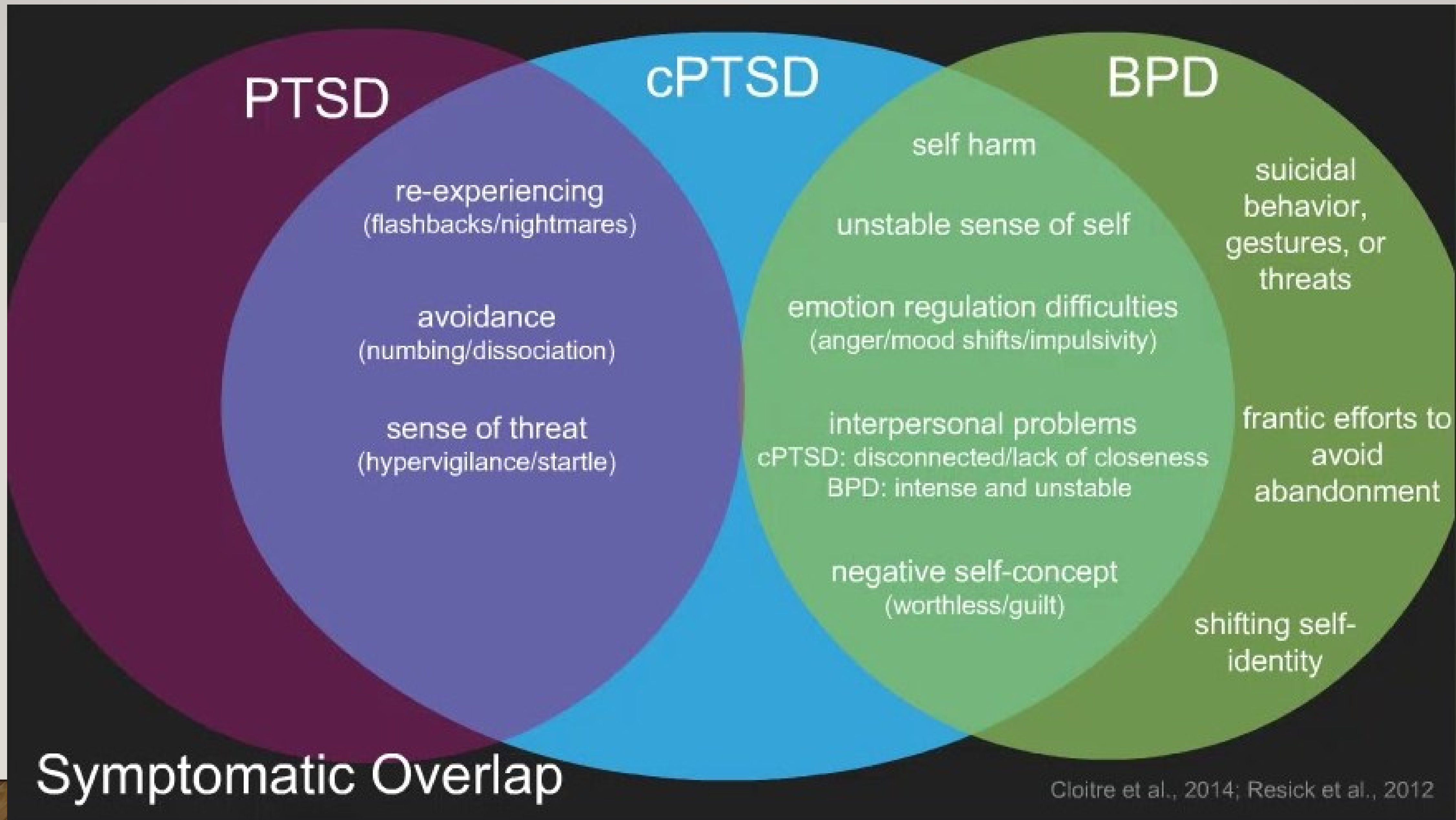
- And so on – trauma is thought to be a risk factor for many forms of ill-health, physical and emotional.

'TRAUMA SPECTRUM'

1. 'Simple' PTSD - single incident
   - overwhelming sense of threat & danger
   - eg rape, assault or serious accident

2. 'Complex' PTSD - repeated incidents
   - interpersonal, persist over time, difficult to escape from
   - overwhelming sense of threat & danger **alongside** a significant breach of trust, coercion, lack of control, powerlessness and domination.
   - eg childhood abuse, domestic abuse, experiences of war

3. Borderline / Emotionally Unstable Personality Disorder
   - attachment trauma / invalidating environments


PTSD
cPTSD
BPD
re-experiencing
(flashbacks/nightmares)
avoidance
(numbing/dissociation)
sense of threat
(hypervigilance/startle)
self harm
unstable sense of self
emotion regulation difficulties
(anger/mood shifts/impulsivity)
interpersonal problems
cPTSD: disconnected/lack of closeness
BPD: intense and unstable
negative self-concept
(worthless/guilt)
suicidal behavior, gestures, or threats
frantic efforts to avoid abandonment
shifting self-identity
Symptomatic Overlap
Cloitre et al., 2014; Resick et al., 2012

POST TRAUMATIC STRESS DISORDER (PTSD)
DIAGNOSTIC CRITERIA

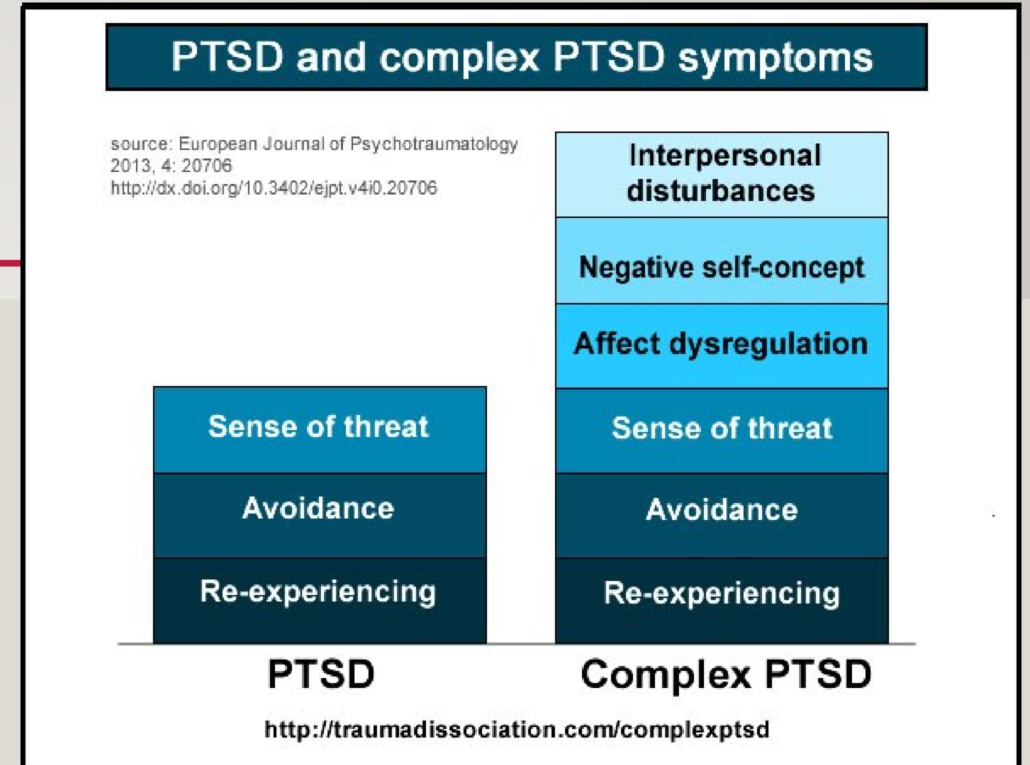
Following experience / witnessing a traumatic event, develop:

- Intrusive thoughts / flashbacks (involuntary and recurrent)
- Intense distress in response to cues relating to trauma
- Avoiding reminders (eg places, triggers)
- Negative thoughts and mood (feel low, detached, stop usual activities)
- Threat arousal symptoms (hypervigilance, sleep problems, exaggerated startle, concentration problems, numbing)

COMPLEX PTSD (CPTSD)

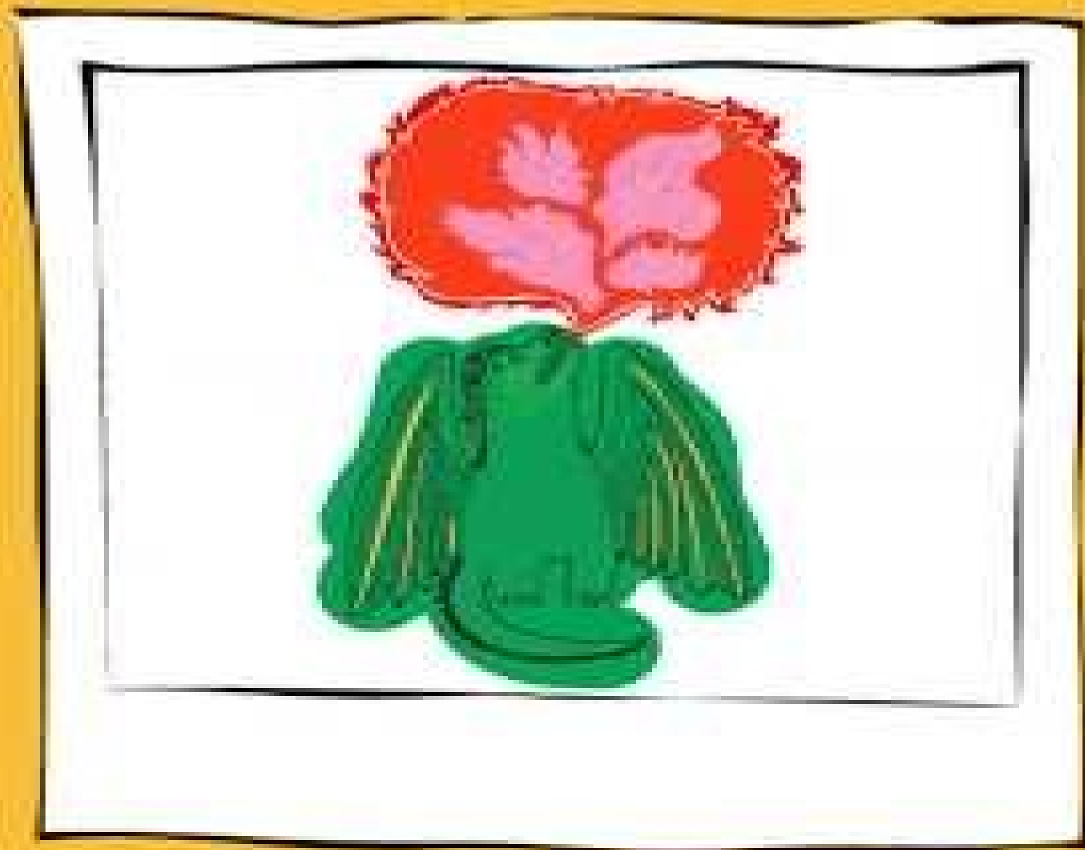
PTSD plus:

- problems of emotion regulation
- persistent negative beliefs about oneself
- difficulties in sustaining relationships



- Post traumatic stress disorder (PTSD) | Talking about mental health - Episode 17 – YouTube (7mins)

Talking about PTSD

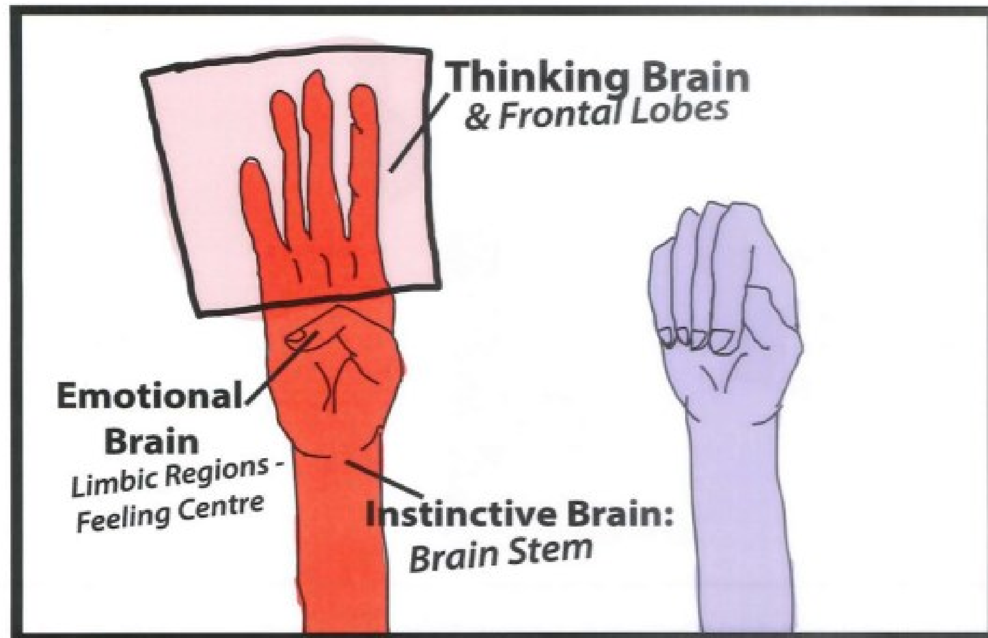


What happens in the brain around threat?

- Trauma and the Brain – YouTube (4m)
- Limbic system detects threat
- Activates survival mode
- Fight / flight / freeze / flop

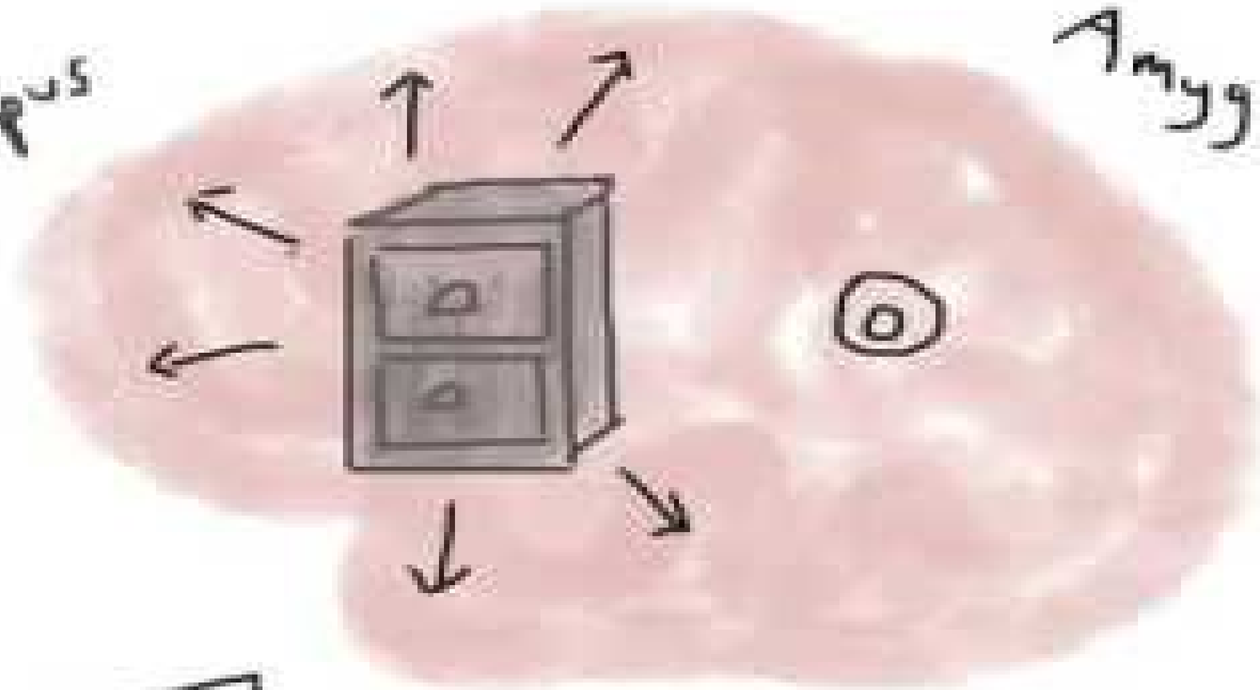
WHY CAN WE NOT ALWAYS CONTROL HOW WE RESPOND TO THREAT?

- Upstairs 'thinking brain' goes offline
- 'Flip our lid'



MEMORY AND TRAUMA

- ‘all clear’
- Thinking brain comes back online to makes sense of experience
- Create meanings
- Attempts to process can be blocked
- Brain Model of PTSD - Psychoeducation Video – YouTube (8’44)


Hippocampus
Amygdala

Normal memories

WHY DO ONLY SOME PEOPLE DEVELOP PTSD?

- Severity, repetition
- Type of event(s) – intentional / unintentional
- If normal memory processing is blocked – shame, guilt
- The relationship context that event(s) takes place in
- **The meaning we make of the event**
- How others responded during and after
- Strengths and resources / protective factors
- Many people will be resilient and recover from the impact of traumatic events or even experience ‘post traumatic growth’

WHAT MEANINGS DO WE MAKE OF TRAUMATIC EXPERIENCES?

'Shattered assumptions'

"the world is benevolent,

the world is meaningful,

and I am worthy"

(Janoff-Bulman)

- It's my fault
- I'm disgusting
- I am worthless
- I am alone
- The world is unsafe
- Nothing makes sense
- Other people can't be trusted

EFFECTS = ON ATTACHMENT, THREAT AND SOOTHING SYSTEMS

- Flashbacks /intrusive memories
- Hypervigilance
- Chronic feelings of shame and self blame
- Difficulties regulating emotions
- Fragmented sense of self
- Chronic over-arousal
- Difficulties trusting others
- Dissociation

DISSOCIATION

Three meanings of dissociation – YouTube (4’51)

- An experience of dissociation – depersonalisation, derealisation
- ‘Switching’ between parts in DID
- Not integrating feelings / ‘cut off’

- Dissociation | Talking about mental health - Episode 16 – YouTube (6’39)

- Questions – thoughts?

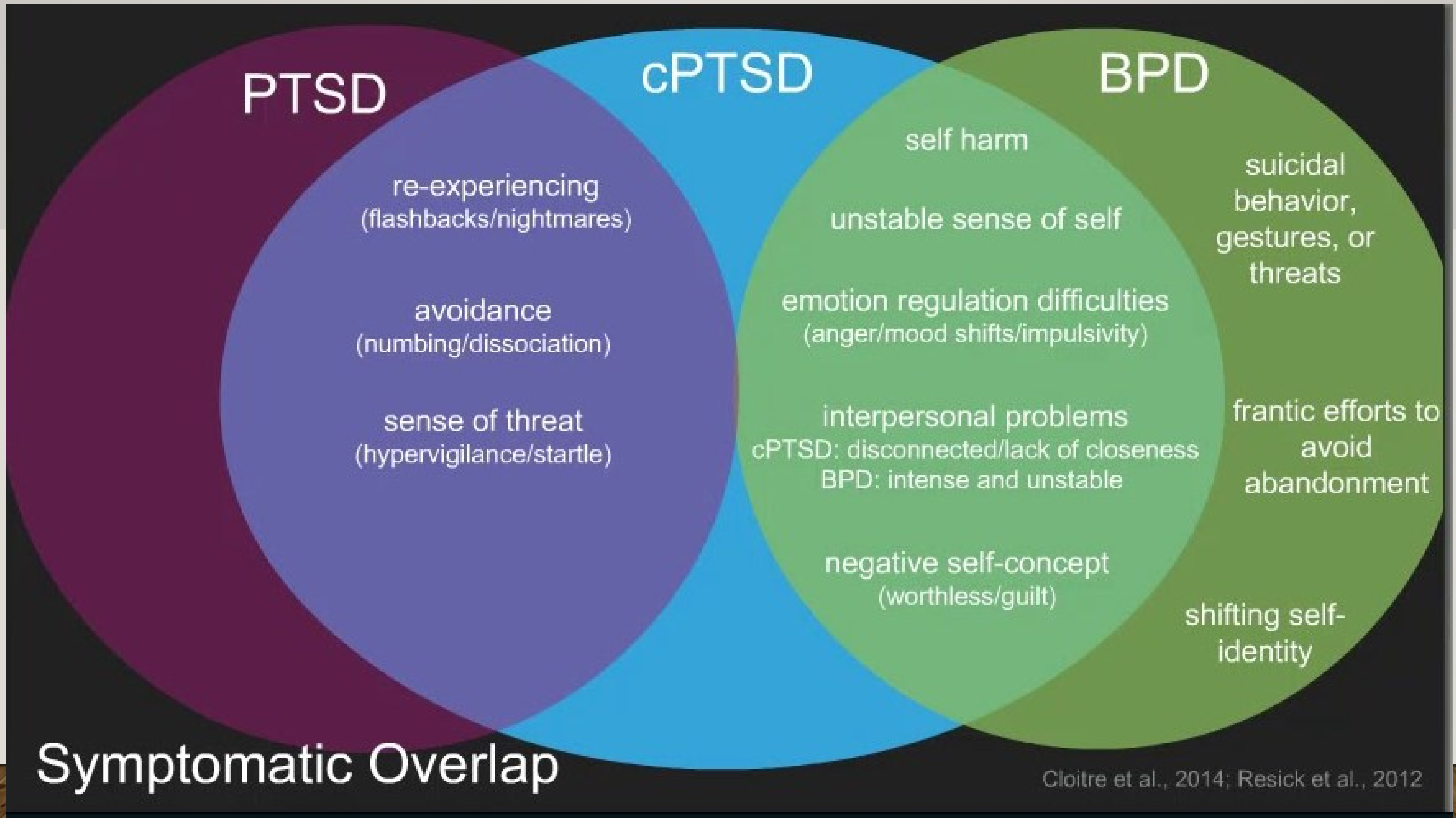
CAROLYN SPRING

THREE MEANINGS OF DISSOCIATION

Talking about dissociative disorders

TRAUMA AND SUBSTANCE USE OFTEN GO TOGETHER

- Attempt to cope - but may perpetuate or worsen symptoms over time
- Reduces hyper arousal symptoms at biological level - but in longer term increases these through neuroadaptation
- Numbs feelings of shame - also can create new feelings of shame
- Can stop intrusive memories - can also make intrusions worse
- Can bring positive feelings in the absence of these - usually short term only
- Perpetuates blocked processing


PTSD
cPTSD
BPD
re-experiencing
(flashbacks/nightmares)
avoidance
(numbing/dissociation)
sense of threat
(hypervigilance/startle)
self harm
unstable sense of self
emotion regulation difficulties
(anger/mood shifts/impulsivity)
interpersonal problems
cPTSD: disconnected/lack of closeness
BPD: intense and unstable
negative self-concept
(worthless/guilt)
suicidal behavior, gestures, or threats
frantic efforts to avoid abandonment
shifting self-identity
Symptomatic Overlap
Cloitre et al., 2014; Resick et al., 2012

‘PERSONALITY DISORDER’

‘PERSONALITY DISORDER’

- An **enduring pattern** of **emotional** and **cognitive** difficulties which affect the way in which **the person relates to others** or **understands themselves**.
- This pattern of behaviour is **pervasive** and occurs across a broad range of social and personal situations
- Is a **long standing** difficulty which always **appears in childhood or adolescence** and continues into later life
- May lead to significant problems in **occupational** and **social** performance

The Consensus Statement for People with Complex Mental Health Difficulties who are diagnosed with a Personality Disorder

‘PERSONALITY DISORDER’

- ‘PD’ difficulties are frequently caused by trauma
- Attachment / relational trauma
- Rates of childhood trauma among individuals with PD are high
- 73% report abuse, of which 34% is sexual, and 82% report neglect
- When you hear PD, think TRAUMA

Attachment and Personality Disorders: A Short Review | FOCUS (psychiatryonline.org)

"A lot of people see you as untreatable.

You're not seen as a human being but as a diagnosis. Everything you do is seen in that light."

"When i found out about
personality disorder
i knew i was not
the only one

who had
wacky moods w
and weird things
going on in my head."

ATTACHMENT THEORY (BOWLBY, AINSWORTH, FONAGY)

- Attach for **survival** – physical and emotional
- Innate system of behaviours designed to maintain relationship with caregiver
- Secure base for exploration, and to return to in moments of danger
- Need balance between exploration and attachment/closness
- 'Attunement' and subsequent emotion literacy & regulation skills, mentalising

ATTACHMENT STYLE

- Infant must adapt to caregiver's behaviour
- Under no circumstances drive the adult away
- Develop expectation of what caregiver will do in response to our needs
- 'Secure'– 'insecure-anxious' – 'insecure-avoidant' – 'disorganised'
- No 'good' or 'bad' style – adaptation for survival

STRATEGIES TO ELICIT CLOSENESS AND CARE

- Unpredictable, inconsistent parent, preoccupied with own problems
- **Shout loudly** so caregiver notices you
- Show emotion –only way to get help
- "Ill be safe if I can get you to stay close and keep your attention – I have to shout to make sure you notice me"

- Hostile / rejecting parent who doesn't like/can't cope with shows of neediness
- Experience of being rejected for expressing needs
- **Sit quietly** so as not to annoy caregiver
- Suppress emotion - I'm fine / 'be good'
- "You don't like it when I get upset and show emotion, I'll shut off my feelings to keep you close"

DISORGANISED ATTACHMENT

FEAR WITHOUT SOLUTION

- A ‘collapse’ of strategy (I don’t know what to do to get your help)
- When attachment figure is both safe haven and source of danger itself
- Biologically pre-programmed to turn to caregiver
- Abuse
- Caregiver may have unresolved trauma in own life - triggered by child’s attachment need
- “You scare me, but I need you”

- Difficulties trusting people / building relationships - suspicious
- Becoming overly self reliant – not asking for help - isolated
- Cutting off /shutting down emotions - then explode
- Being preoccupied with relationships – clinging – overinvesting – poor boundaries
- Putting up with being mistreated
- Putting others' needs first / 'compulsive care-giving'
- Over-compliance
- Sensitive to / hypervigilance for signs of rejection / being let down – react with rage
- Argumentative - controlling
- Expressing needs in ways that inadvertently push people away
- Under-developed emotion coping skills
- Poor ability to mentalise – blaming of others, stuck in own perspective

'HARD TO ENGAGE' 'ATTENTION-SEEKING' 'MANIPULATIVE' 'SABOTAGING'

‘INVALIDATING ENVIRONMENTS’

- Validating environment - caregiver pays attention to emotion, takes it in, ‘mentalises’ the child (what’s going on for you? reflects it back, names emotion & soothes it)
- Teaches child to recognise, name, understand emotions, and internalise skills to soothe.
- Invalidating environments
  - Simple mismatch in temperament
  - Depressed or preoccupied parent
  - Neglect through to abuse
- Child’s emotions disregarded / invalidated by significant others
- Response - critical, punishing, inappropriate, dismissive, shaming, absent, erratic

EFFECTS OF INVALIDATING ENVIRONMENTS

- Believe your emotions have no value, are wrong, you are defective/ to blame.
- Poor development of skills to regulate emotions
- Develop other ways of managing emotions
- Negative sense of self and others
- Difficulties with trust, closeness and connection to others
- Fear being abandoned because you’re not good enough
- Hard to mentalise (what’s going on in my mind and in the mind of others)

WHAT HELPS TRAUMA-BASED DIFFICULTIES

- Experience of a safe relationship
- Kindness and empathy
- Validate emotions – “it makes sense”
- A calm and thoughtful response
- Consistent empathically held boundaries
- Help people learn how to keep themselves safe
- Give hope
- Empower
- Connection
- Teach emotion regulation skills
- Help people understand the impact of trauma
- Reduce shame and self criticism – teach self-compassion

TRAUMA FOCUSED THERAPY

- Stabilisation crucial
- Lifestyle & substance use
- Reprocessing the trauma memory
- Evaluate appraisal and develop new meanings

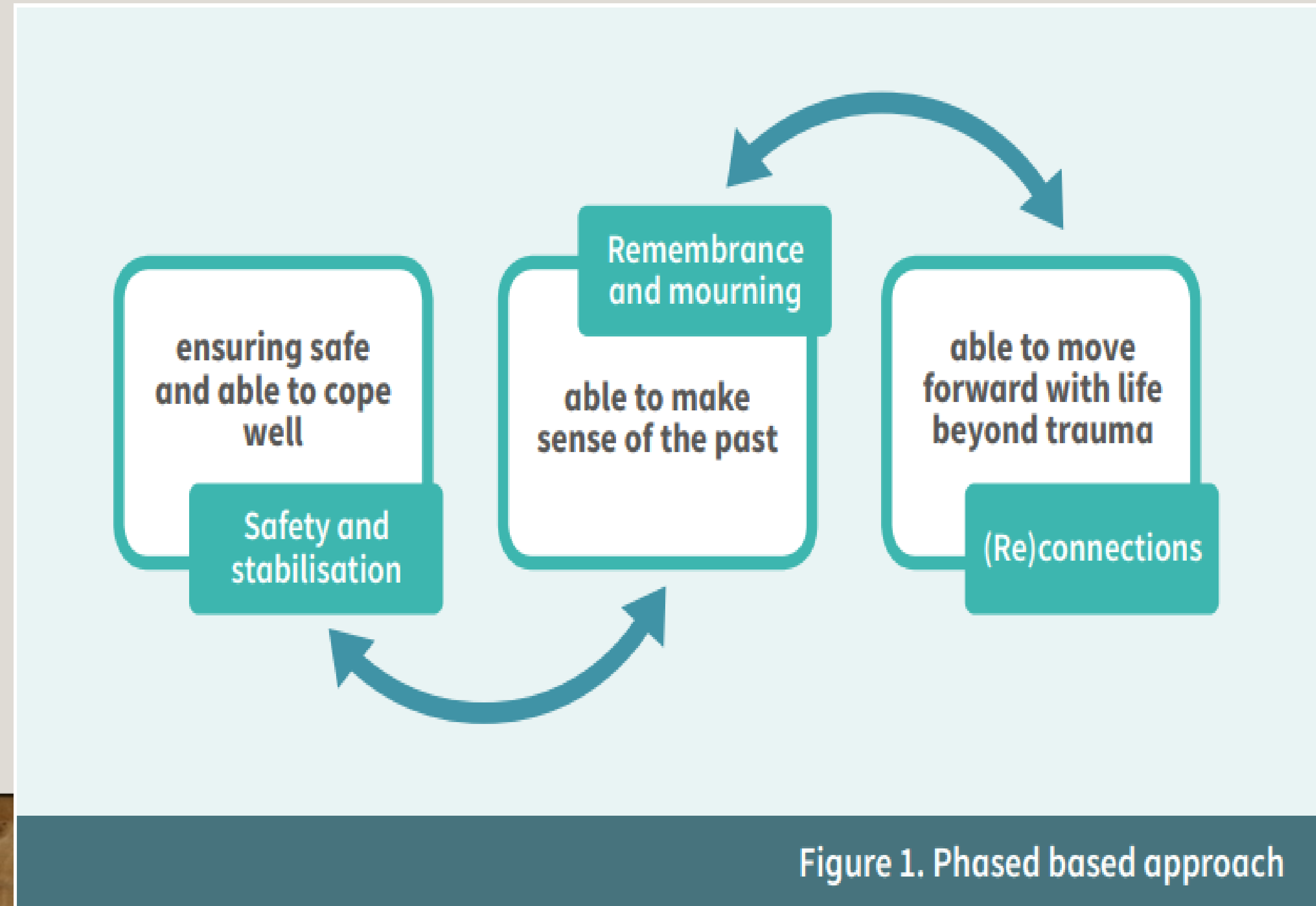


Figure 1. Phased based approach

SERVICES OFFERING SUPPORT AND THERAPY

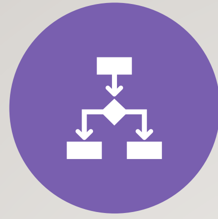
- **PWS** – single event trauma
- **Lifecraft** – 2 years counselling, can have a trauma focus
- **Choices** – 2 years counselling around childhood sexual abuse, and symptom management
- **CGL Psychology** - 1-off educational CBT workshop 'Understanding Trauma', Seeking Safety group for phase 1 stabilisation,
- **MIND** PD peer support
- **MIND** Waves programme
- **Personality Disorder Community Service** (PDCS)
- **Group Therapy Centre-** CBT group therapy and long term group psychodynamic psychotherapy

TRAUMA-INFORMED CARE

CAMBRIDGE
WISBECH
PHE
CRS

HUNTINGDON
CRIMINAL JUSTICE
FAMILY SAFEGUARDING

SAFETY



CHOICE

COLLABORATION

TRUST

EMPOWERMENT

- Is not designed to treat trauma
- Develops services that assume SUs will be managing effects of trauma
- Considers the effect that trauma may have on engagement with a service
- Sees client behaviour & our provision through this lens
- Should remain strengths focused

TRAUMA INFORMED CARE

- Recognises that services can unintentionally re-traumatise service users through their operational practices, power differentials, by having overly strict or authoritarian rules, multiple assessment processes requiring repeated re-telling of difficult life events, frequent handovers/turnover of key workers and sudden/unplanned terminations/breaks in treatment/relationships.

HOW TRAUMA CAN AFFECT ENGAGEMENT WITH HELP

- Often highly sensitive to reminders of previous trauma
    - Feeling unsafe
    - Feeling trust is breached
    - Feeling coerced / lack of control
    - Feelings of powerlessness or being dominated
- May respond as if original trauma
- Threat = escape, avoid, fight, dissociate, fawn

IN YOUR TEAMS, PLEASE DISCUSS:

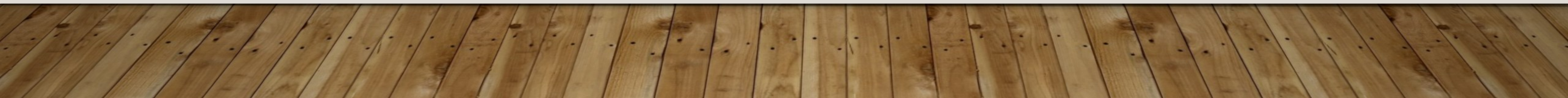
1. What can we do as professionals to help someone feel safe?
2. How might a persons' experiences of relationships in childhood affect the relationship between them and professionals?
3. How might we use this to understand and respond to behaviours we find difficult?

IN YOUR TEAMS, PLEASE DISCUSS:

1. What do we already do well in terms of TIC?
2. Is there anything we could work on to improve our TIC?
3. Trauma informed systems / management - what do you need as staff to feel safe and create safety for clients?

- Create safe physical environment
- Free from interruptions where possible
- Build relationships that aim to be caring, consistent, reliable, boundaried (SAFE)
- Understanding that we are in positions of power
- Pay full attention to our clients
- Do what we say we're going to do
- Work at being compassionate even when this feels difficult
- Be sensitive to different needs, gender in particular

- Be transparent about our processes
- Validate people's experiences in life
- Attention to endings - planning and notice, say goodbye
- Understand behaviour through trauma lens
- Offer choice where possible
- Collaborate
- Recognise strengths
- Elastic tolerance (vs strict rules)
- Talk to / support each other
- Model compassion
- Practice good self care



TO RESPOND IN A THERAPEUTIC WAY

- We need to be able to think and respond, not react
- "What is going on behind the behaviour" / what need is the person trying to meet?
- Reframe 'attention seeking' as 'attention needing / attachment-seeking'
- Validate the feeling
- Stay calm and de-escalate
- Be boundaried – safe and predictable
- We need to feel supported/safe to do this
- Reflective practice

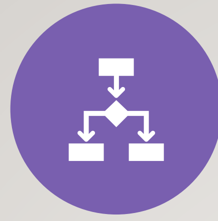
VICARIOUS TRAUMA

- Witnessing traumatic events & hearing others' trauma
- Being empathic leaves us vulnerable
- Feel feelings, see images, left preoccupied
- This is a normal response
- Can also trigger existing trauma
- Use formal and informal supports and supervision
- Prioritise good self-care

WE CAN BE AFFECTED BY HOW OUR CLIENTS RESPOND TO US

- We all come into these sorts of roles for various reasons – but it is likely that we want to help people at some of the most difficult points of their lives
- This can expose us to behaviour and situations that can be upsetting, hurtful or even traumatising (or retraumatising) for us
- Meanings we might make:
  - I'm no good, I'm not helpful, I've made it worse
  - I'm not safe
- Being aware of ourselves individual vulnerabilities and needs is important

SAFETY



CHOICE

COLLABORATION

TRUST

EMPOWERMENT

1. **Realise** how common the experience of trauma and adversity is
2. **Recognise** the different ways that trauma can affect people
3. **Respond** by taking account of the ways that people can be affected by trauma to support recovery
4. **Resist re-traumatisation** - offer a greater sense of choice and control, empowerment, collaboration and safety
5. **Relationships** - recognise the central importance

FINAL THOUGHTS

- Reflections on today / this process
- Are there tensions for us?
- Taking this forward
- What does trauma informed management look like?
- Feedback

THE END

Thank you for your thought with this

Next session is Working with (trauma related) Distress

Look after yourselves ☺

Opening Doors:
Trauma Informed Practice
for the Workforce
POLICE