Trauma-informed care

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Sheryl Spithoff MD CCFP
Leslie Molnar MSW RSW
Women’s College Hospital, University of Toronto
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FACULTY/PRESENTER DISCLOSURE

- Faculty: Sheryl Spithoff
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- Faculty: Leslie Molnar
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  - Employed at Women’s College Hospital
Overview

• Adverse childhood experiences (ACE) study
• Background on trauma- definitions, prevalence in Canada
• Trauma-informed care
  – Importance, evidence
  – Screen for trauma
    • Grounding techniques
• Trauma resources in the community (Leslie Molnar)
  – What to look for in a trauma therapy program
  – Seeking Safety program at WCH
  – Review several communities
Susan, 55 years old

- Middle/upper class background
- Substance use
  - Heroin and prescription opioids
- Unstable relationships
  - Daughter lives with her ex-partner
- On ODSP for anxiety and depression
- Cervical cancer
- Early COPD
Clustering

- Clustering of risk factors/diseases
  - Substance Use Disorders
    - Alcoholism and alcohol abuse/Illicit drug use/Smoking
  - Mental Health
    - Depression/Suicide attempts
  - Risky sexual behaviours
    - Multiple sexual partners/Sexually transmitted infections/Unintended pregnancies/Early initiation of sexual activity
  - Intimate partner violence
  - Health consequences
    - Ischemic heart disease (IHD)
    - Liver disease
    - Chronic obstructive pulmonary disease (COPD)
Clustering of conditions

- CDC and Kaiser Permanente Health Group
- 17,000 new patients between 1995-1997
- Confidential survey
  - Health status
  - Adverse childhood experiences
  - Followed over time
## Adverse Childhood Experiences

<table>
<thead>
<tr>
<th>ACE Category*</th>
<th>Women (N = 9,367)</th>
<th>Men (N = 7,970)</th>
<th>Total (N = 17,337)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abuse</strong></td>
<td></td>
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<tr>
<td>Emotional Abuse</td>
<td>13.1</td>
<td>7.6</td>
<td>10.6</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>27.0</td>
<td>29.9</td>
<td>28.3</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>24.7</td>
<td>16.0</td>
<td>20.7</td>
</tr>
<tr>
<td><strong>Neglect</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional Neglect¹</td>
<td>16.7</td>
<td>12.4</td>
<td>14.8</td>
</tr>
<tr>
<td>Physical Neglect¹</td>
<td>9.2</td>
<td>10.7</td>
<td>9.9</td>
</tr>
<tr>
<td><strong>Household Dysfunction</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Mother Treated Violently</td>
<td>13.7</td>
<td>11.5</td>
<td>12.7</td>
</tr>
<tr>
<td>Household Substance Abuse</td>
<td>29.5</td>
<td>23.8</td>
<td>26.9</td>
</tr>
<tr>
<td>Household Mental Illness</td>
<td>23.3</td>
<td>14.8</td>
<td>19.4</td>
</tr>
<tr>
<td>Parental Separation or Divorce</td>
<td>24.5</td>
<td>21.8</td>
<td>23.3</td>
</tr>
<tr>
<td>Incarcerated Household Member</td>
<td>5.2</td>
<td>4.1</td>
<td>4.7</td>
</tr>
</tbody>
</table>

[http://www.cdc.gov/ace/prevalence.htm](http://www.cdc.gov/ace/prevalence.htm)
ACE study

• Linked to health conditions
• For numerous health conditions response to ACEs was strong and graded
Risk of depression in women with more Adverse Childhood Experiences

http://www.cdc.gov/violenceprevention/acestudy/outcomes.html
Risk of adult heart disease

http://www.cdc.gov/violenceprevention/acestudy/outcomes.html
Current AUD, ever illicit drug use

Risk of Adult Substance Abuse Increases with more Adverse Childhood Experiences (ACEs)

Self-Report: Alcoholism

Self-Report: Illicit Drugs

http://www.cdc.gov/violenceprevention/acestudy/outcomes.html
Definition

• Trauma:
  – An out of control frightening event/situation
  – Overwhelms an individual’s resources for coping
    • Creates fear, horror and helplessness

• What is multigenerational trauma?
Multigenerational trauma

• Trauma experienced by parents has an impact on children
  – Effects on attachment and identity
• Examples
  – Children of holocaust survivors
  – Children of parents who were in residential school system
    • Starting in 1850s approximately 150,000 First Nation, Inuit and Metis children were removed from their homes and placed in government boarding schools
      – Separation from family, culture
      – Experienced physical abuse, neglect, sexual abuse
    • Traumatic to whole communities- those left behind as well
Prevalence in Canada

- Canadian Community Health Survey (Afifi 2014)
  - Self-reported prevalence of child abuse - 32%
    - Physical (26%), sexual (10.1%), exposed to intimate partner violence (7.9%)
  - Strong association with adult mental health problems including suicide attempts and drug abuse/dependence

- Canadian stats - adulthood
  - 6% report current or most recent past partner physically or sexually victimized them (Stats Canada 2011)
  - 1/4 women are sexually assaulted in lifetime (Sexual assault Canada 2012)
Trauma: consequences

• Can profoundly effect how an individual views world/interacts with others
• Can have lifelong consequences
  – Most damaging is repetitive, interpersonal, younger age
• Two people can experience the same event differently
  – Past experiences/Previous trauma
  – Mental health/Current state
  – Supports- ACE study
Trauma: consequences

• Victims of interpersonal traumas are at higher risk of experiencing more interpersonal traumas
  – Underlying risks
  – Effects of trauma itself
    • Loss of stability/safety
      – E.g. teen who leaves home because of abuse
    • Abnormal neuro-development
    • Substance use disorders (SUDs)
      – Survival sex work/Crime
Consequences: PTSD

• PTSD
  – Re-experience the event through flashbacks, dreams, intrusive thoughts, cues in the environment
  – Avoidance of stimuli that might provoke re-experiences
  – Negative effect on cognition and mood
  – Increased arousal (difficulty falling asleep, anger, hyper-vigilance etc)
  – Impact on function
Consequences: Complex PTSD

- Effects of prolonged and repetitive interpersonal trauma beginning at an early age, with perceived or actual inability to escape
  - Most severe symptoms
    - PTSD symptoms
    - Self-harm, chronic suicidality, addictions
    - “Difficult” behaviours
  - Result of abnormal neuro-development
  - Coping in ways that are somewhat effective (at least in short-term)
  - Coping with complicated lives
    - Addictions, other mental health problems, poverty, ongoing trauma
ACEs & addiction

Researchers estimated that ACEs were responsible for at least ½ to 2/3 of drug addictions

- ACEs affect neuro-development
  - Dysfunction in hypothalamic-pituitary-adrenal (HPA axis), in dopamine, serotonin, endorphin pathways, in development of pre-frontal cortex
  - Problems with affect-regulation, attachment, identity, relationships, sense of meaning
  - High levels of anxiety, depression, suicidality
  - Rarely feel at ease and relaxed
ACEs & addiction

• Substance use affects may of these neural pathways
  – Endorphins, serotonin, dopamine
    • Dopamine release from many psychoactive substances prone to misuse is often 5-10x greater than physiological (food, sex, companionship)
  – For the first time ever enough for those with trauma to feel happy, at ease
    • “Two drinks short of normal”
    • Coping mechanism

– However, over time brain responds by decreasing dopamine release and dopamine receptors (also changes in other pathways)
  • Leads to tolerance and withdrawal
ACEs and addiction

- [http://www.youtube.com/watch?v=yCzXbsGAXiI](http://www.youtube.com/watch?v=yCzXbsGAXiI)

- Dr. Gabor Mate: These are the abused children we had so much compassion for, but as adults we treat them as criminals.
Trauma-informed care
Trauma-informed care

• Goal: care that is appropriate and welcoming to those affected by trauma (Trauma-informed toolkit Klinic Health Centre 2013)
  – Replaces the labeling of patients as being sick, resistant or uncooperative with that of being affected by an injury
  – Shifts the conversation
    • from “What is wrong with you?”
    • to “What has happened to you?”

• Trauma-informed care
  – Reduces drop-out rates (Elliot 2005)
  – Encourages help-seeking (Brown 2000)
Re-traumatizing

• Health care can be traumatizing particularly for those with inter-personal trauma
  – Interpersonal
  – Intimate
  – Power differential
Trauma-informed care

- The core trauma-informed principles are:
  - Acknowledgement
    - Recognize and communicate that trauma is pervasive
  - Trust
    - Be open, honest about your skills, knowledge, limitations
    - System should be transparent, accommodating, consistent boundaries
  - Collaboration- choice and control
    - All aspects of engagement with healthcare system
  - Compassion
  - Strength-based
    - Acknowledge resilience and that methods of coping are understandable/logical
  - Safety
    - Emotional safety- avoid re-traumatizing
    - Help keep patients safe from self-harm- have a safety plan
    - Building should be physically safe- lit, secure
Screening for trauma

- Limited evidence to recommend universal screening for trauma
- Mixed/limited evidence for universal screening for current IPV
  - WHO and Canadian Task Force on Preventative Health Care (CTFPHC) (2013)- recommend against screening for IPV
  - US-PSTF (2013) recommends screening
  - Cochrane concludes insufficient evidence (2015)
  - Strongest evidence is for IPV in pregnant women (ACOG)
    - Large RCT found it makes a difference (Kiely 2010): improves birth outcomes, reduces depression, smoking
      - Intervention is counseling from SW (info on danger assessment, safety behaviours, community resources)
Targeted screening/ Case ID

• Patients with mental health problems, addictions, self-harm, EDs, chronic suicidality

• Patients in these populations find screening acceptable
  – Surveys find patients think it is appropriate for physicians to ask about childhood abuse and intimate partner violence
    • Reduces stigma, leads them seek helps, make changes

• Gives patients access to specialized care
  • Specialized trauma care shown to improve outcomes
Specialized trauma care

- **PTSD treatment**
  - Psychotherapy (Cochrane 2013)
    - Trauma-focused CBT (TF-CBT) is most effective (CBT is as well)
    - EMDR (eye movement desensitization and re-processing)
    - Group TF-CBT effective but higher drop-out rates
  - Medications (Cochrane 2006) (Jeffreys 2012- review)
    - SSRIs and venlafaxine - first-line
    - Prazosin- alpha blocker
      - good evidence for nightmares
      - Start at 1mg qhs, increase to 3-10 mg
      - Care with those at risk of hypotension
    - Benzos- poor outcomes
    - Anti-psychotics- limited evidence, significant side effects
Specialized trauma treatment

• PTSD and substance use disorders (SUDs)
  – Review article (Najavits 2013) all treatment interventions for PTSD and SUDs
    • Most had positive outcomes, particularly for PTSD
    • Best evidence for combined, integrated treatment (Same providers, all one program)
      – Consistently best outcomes for SUDs
Dialectical behavioural therapy

• Effective for patients with borderline personality disorders
• Recognizes that most with BPD- raised in “profoundly invalidating environments”
  – Lack skills to cope with distress
• Approach includes acceptance of person, and encouragement to make change
• Therapy designed to help people change unhelpful behaviours
  – Distress tolerance
  – Acceptance
  – Mindful awareness
  – Interpersonal effectiveness- getting needs met without destroying relationships/ losing self respect
Taking a Trauma History

Some slides from Leslie Hughes MSW, Women’s College Hospital
Taking a trauma history

• Health care providers express the following worries:
  – I won’t know how to respond
  – I won’t have the time to hear the whole story
  – I don’t have the skill set and will make things worse
  – I may respond with emotion/ hard to hear/ reminders of own struggles
  – I don’t think it’s the right time to ask about trauma
Ask and Inform

• Select appropriate time
  – Staged screening may be appropriate

• Give an explanation of why you are inquiring about trauma
  – “We know that childhood histories of abuse/trauma are much more common than once thought. As well, studies show that childhood and adulthood trauma can have an impact on physical and mental health.”

• Example of a screening question:
  – “Have you experienced any difficult life events (abuse, violence, trauma) that think might be related to some of the things you are struggling with now?”

Adapted from the Handbook on Sensitive practice for health Care practitioners: Lessons from adult survivors of childhood sexual abuse (p.62, 2009)
Susan

• Sexually abused by adult male relative aged 8-12
  – Felt unable to tell her mother or father at the time
  – Ongoing flashbacks, anxiety, anger
  – Has never disclosed to any family members

• She was also assaulted and raped by a past partner

• Has talked to her FP
• No trauma therapy in past
• Susan feels there is a strong link between her substance use and PTSD related to the abuse
Responding to Disclosure

• Empathy
  – I appreciate that you shared this with me today
• Validate- Substance use/anger/dissociating is a common way of coping
• Reflective listening
• Provide information
  – We know that interpersonal trauma can have a significant impact on health and wellbeing
• Identify clients’ needs and explore implications for care
Avoid

• Asking for a detailed account of trauma history
• Touch
• Making assumptions
  • e.g. “I am sure life is much better without your partner controlling you,”
    “You must really hate your father for what he did.”
• Minimizing someone’s experience
  • (e.g. “At least you don’t __________,” “If you look on the bright side, __________)
• When recognizing resiliency, be sure to also acknowledge the struggle
  • e.g. “Given all these struggles, what has allowed you to cope?”

• What if your patient starts crying or dissociating in your office?
• Patients who experienced interpersonal trauma often have difficulty modulating their affect
  • Pulled to the past or fearful of future harm
• Pay attention to signs of a trauma response
• If needed, pause and help the individual to connect to the present moment
• Do not touch the person or allow them to leave without time to ground
Grounding

• Detaching from emotional pain
  – Get in touch with the present moment
  – Direct attention to something else

• Make a suggestion- for example: “I notice you are getting pulled into the past. Can we try something together?”
  – Notice that you’re holding your coffee cup, do you notice the temperature?
  – Bring your attention to your feet, notice they are on the floor, dig your heels in a bit and remind yourself “I’m here”
  – Do you notice any particular colours in this space? Turning your head and shifting your gaze can help.
Assessing if Trauma is Resolved

• Is the trauma having an ongoing effect?
  – Thoughts, flashbacks, anxiety
  – Substance use to cope with PTSD symptoms

• Ask your patient:
  – What is it like telling your story now?
  – Does if affect your life currently?

• Have they had any therapy in regards to their trauma?
• Who have they disclosed to?

• Next steps...
CONNECTING TO SPECIALIZED TREATMENT

Leslie A. Molnar BSW, MSW, RSW
1. Service that is specific to the trauma experience – trauma experienced in childhood or adulthood; simple or complex trauma

2. Based on certain principles:
   – Safety – individuals physical and psychological safety – Stage 1
   – Voice – individuals are given the opportunity to be heard and respected
   – Choice – services are flexible, individualized, culturally competent and promote dignity
   – Empowerment

3. Strength based and Skill building – understanding symptoms as adaptations

4. Ideally integrated i.e. PTSD symptoms and substance use, chronic illness and trauma
Trauma Therapy Treatment

- Trauma disrupts the body’s natural equilibrium
- Freezes you in a state of hyperarousal and/or hyporarousal and fear

- Must address this imbalance and reestablish the individuals’ physical sense of safety and help move them into window of tolerance.
Trauma Therapy Treatment Approaches

Somatic Experiencing:
- Focus = bodily sensations, rather than thoughts and memories
- Person concentrates on what’s happening in their body
- From there, the natural survival instincts take over, safely releasing this pent-up energy through shaking, crying, and other forms of physical release.

EMDR (Eye Movement Desensitization and Reprocessing)
- Elements of cognitive-behavioral therapy with eye movements or rhythmic, left-right stimulation.
- Back-and-forth eye movements = “unfreezing” traumatic memories

Cognitive-behavioral therapy
- Process and evaluate thoughts and feelings about a trauma.
- Helpful when used in addition to a body-based therapy such as somatic experiencing or EMDR.

*http://www.helpguide.org/articles/ptsd-trauma/emotional-and-psychological-trauma.htm*
Case Study

After considering Susan’s symptoms:
1. What would you keep in mind when considering referring Susan to additional services?
2. As an example, what might you ask Susan?
3. What are some of Susan’s personal strengths that you can identify from this short vignette?
Seeking Safety Treatment Group

An evidence-based treatment for PTSD Symptoms and Substance Use
Treatment Rationale

• PTSD and substance abuse have been found to co-occur, regardless of nature of trauma or type of substance used (Keane & Wolfe, 1990; Kofoed et al., 1993).
• This dual-diagnosis is 2 - 3 times more common in women than in men (Brown & Wolfe, 1994, Najavits et al., 1998c).
• Treatment outcomes (PTSD and substance use) = worse than for other dual-diagnosis patients with substance abuse alone (Ouimette, Ahrens, Moos, & Finney, 1998; Ouimette, Finney, & Moos, 1999).
• Becoming abstinent from substances does not resolve PTSD; some PTSD symptoms become worse with abstinence (Brady, Kileen, Saladin, Dansky, & Beckers, 1994; Kofoed, Friedman, & Peck, 1993; Root, 1989).
• Integrated treatment = more success, more cost-effective and more sensitive to patients’ needs than parallel or sequential approaches
Goals

• To establish safety – hope that pts will “take home” the idea of safety above all.
• To provide a group experience to learn new coping strategies in areas such as healthy relationships, asking for help, setting boundaries.
• To decrease symptoms of PTSD and substance use by practicing coping strategies.

Najavits 2002
Principles of Seeking Safety

5 Central Ideas:

1. Safety as a priority of this first stage of treatment
2. Integrated treatment of PTSD and substance use
3. Focus on ideals
4. Four content areas; cognitive, behavioral, interpersonal, and case management
5. Attention to therapist process
1. Safety

- discontinuing substance use
- reducing suicidality
- minimizing exposure to HIV risk
- letting go of dangerous relationships*
- gaining control over extreme symptoms
- stopping self-harm behaviors*
- reenact trauma (ignore needs and perpetuate pain).

Participants learn how to:
- ask for help from safe people
- utilize community resources
- care for their bodies

Najavits 2002
2. Integrated Treatment

*System and patient goal:
- “own” both disorders
- recognize their interrelationship
- fall prey less often to each disorder triggering the other.

Participants discover:
- connections between the two disorders
- what order they arose and why
- how each affects healing from the other
- their origins in other life problems (i.e. poverty).

Najavits 2002
3. Focus on Ideals

PTSD and substance use in combination lead to demoralization and loss of ideals.

Loss of:
- Trust, honesty, respect, care, protection, healing, to name a few.

Treatment seeks to restore ideals that have been lost.

By aiming for what can be, patients will summon the motivation for the hard work of recovery.

Najavits 2002
4. Four Content Areas

1. **Cognitive**: CBT based – present, problem-oriented, brief, time-limited, structured, educational. Allows rehearsal of new skills such as problem-solving, cognitive control, relationship skills, self-care.

2. **Behavioral**: End of each session patient identifies a weekly commitment and a plan to connect to a community resource.

3. **Interpersonal**: Patients are guided to notice extreme relationship dynamics that re- evoke trauma (enmeshment) and substance abuse (friends who offer substances).

4. **Case Management**: some patients may require significant assistance in getting the care they need (job counseling, housing, etc.)

Najavits 2002
5. Therapist Process

What is emphasized in this treatment:

• Building an alliance
• Having compassion for patient’s experience
• Using various coping skills in one’s own life*
• Giving patients control whenever possible*
• Modeling what it means to try hard by meeting the patient halfway
• Obtaining feedback from patients
• Paying attention to counter-transference issues*
• Goal = integrate praise and accountability

Najavits 2002
Seeking Safety Group Contexts

• Women, men, transgendered, military veterans, homeless, patients with HIV, minority populations, adolescents, prison populations

At Women’s College Hospital:
• 8 participants, 12 weeks, mixed gender group, closed group
• Twice per year, facilitators – therapist and Psychiatrist
Community Trauma Services

- Peterborough, Ontario
- Barrie, Ontario
- Fergus, Ontario
Peterborough, Ontario

Approximate population – 78,698 (2011)
Median age – 44.6 years


1. Peterborough Regional Health Centre – Women’s Health Care Centre - counseling - (705) 743-4132 or 1-800-419-3111 - http://www.prhc.on.ca/cms/women-s-health-care-centre


Barrie, Ontario

Approximate population – 143,634 (2014)
Median age – 37.2 years


2. Royal Victoria Regional Health Centre – mental health and addictions inpatient/outpatient – referral from physician or community - 705-728-9090 https://www.rvh.on.ca/mhad/SitePages/dayprogram.aspx

3. Athena’s Sexual Assault Counselling & Advocacy Centre – Individual counselling, 24-hour crisis line – support for women 16 yrs and older who have experienced sexual abuse as children or adults. Services available in Alliston, Barrie, Collingwood, Midland and Orillia - 705-737-2884 - http://www.huroniatransitionhomes.ca/services-and-programs/athenas/


Fergus, Ontario

- Approximate population – 19,126 (2011)
- Median age – 35.2 years

1. **Family Services Guelph** - offer a wide range of counseling services for individuals, couples, and groups – has a worker that visits Fergus and Arthur 1 day per week – fee for service – sliding scale - 519-824-2431 or 1-800-307-7078 to schedule an appointment.  [http://www.familyserviceguelph.on.ca/](http://www.familyserviceguelph.on.ca/)

2. **Rural Women’s Support Program** - provides services to women who have been or are in an abusive relationship, or have experienced childhood sexual abuse/incest, recent or past sexual assault, harassment and/or stalking - offices in Erin, Fergus, Mount Forest and Palmerston – self-referral - 519-843-6834 (Fergus) - [http://www.gwwomenincrisis.org/get-help/rwsp/](http://www.gwwomenincrisis.org/get-help/rwsp/)

3. **Canadian Mental Health Association** – offers case management, resources and supports - [https://wwd.cmha.ca/our-services/](https://wwd.cmha.ca/our-services/)


General Resources

Websites:

3. CAMH.ca - http://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/Trama/Pages/default.aspx
Resources

Books:
1. “Treating the Trauma Survivor: an essential guide to trauma-informed care” by Anne Fourt, Carrie Clark, Maithili Shetty, Catherine C. Classen
2. “Seeking Safety: A treatment manual for PTSD and Substance Use” by Lisa Najavits

Hospitals/Agencies:
1. Women’s College Hospital – Trauma Therapy Program and Substance Use Service - [http://www.womenscollegehospital.ca/](http://www.womenscollegehospital.ca/)
2. The Jean Tweed Centre - [http://jeantweed.com/resources/](http://jeantweed.com/resources/)
3. Toronto Western Hospital – Addiction Outpatient Services [http://www.uhn.ca/PatientsFamilies/Health_Information/Health_Topics/Documents/Addiction_Outpatient_Service.pdf](http://www.uhn.ca/PatientsFamilies/Health_Information/Health_Topics/Documents/Addiction_Outpatient_Service.pdf)
Additional learning

Books and Articles:
• Trauma and Recovery, Dr. Judith Herman

Additional training:
• Hinks Dellcrest- Trauma and Resiliency
• Mount Sinai Psychotherapy Institute: Trauma Fundamentals
• Leading Edge Seminars
Questions?