Trauma Informed Care: A Strength Based Approach to Substance Abuse Treatment

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Objectives

- Define and discuss the key features/components of trauma informed care
- Identify common physical, psychological, and emotional effects of trauma
- Learn to identify client behaviors as trauma reactions and respond in a way that builds on client strengths and helps a client maintain their dignity

The Problem

- The prevalence rate of physical/sexual abuse among women in substance abuse treatment programs is estimated to be 30-90%.
- ETOH & Drug problems increase women's vulnerability to violence
- Misidentified or misdiagnosed trauma-related symptoms interferes with help seeking, hampers engagement in treatment, leads to premature termination of tx and increases the likelihood of relapse

1. The National Trauma Consortium

Identifying Subsequent Treatment Needs

- Evidenced-Based screening and assessment tools
- SAMHSA: Creating a TIP aimed at identifying a number of trauma screening/assessment instruments

Trauma Informed Care

- Understanding that client vulnerabilities or triggers may be exacerbated by traditional service delivery approaches (www.samhsa.gov)
- Case management is grounded in and directed by a thorough understanding of the neurological, biological, psychological, and social effects of trauma and violence on humans and the prevalence of these experiences in persons who receive mental health services (www.socialwork.buffalo.edu)

What is psychological trauma?

According to the Sidran Institute for Traumatic Stress Education and Advocacy:

A psychological trauma "is the unique individual experience of an event or enduring conditions in which…"

- The individual's ability to integrate his/her emotional experience is overwhelmed or
- The individual experiences (subjectively) a threat to life, bodily integrity, or sanity.

A traumatic event or situation creates psychological trauma when:

- It overwhelms the individual's ability to cope
- Leaves the person fearing death, annihilation, mutilation or psychosis
- Person may feel emotionally, cognitively and physically overwhelmed
- Often caused by an abuse of power, betrayal of trust, entrapment, helplessness, pain, confusion, and/or loss.

Trauma can be…

- A single event, i.e. a death, an accident, crime, surgery, etc.
- Chronic or repetitive experiences of child abuse, neglect, combat, urban violence, concentration camps, battering and other abusive relationships
- Experienced vicariously through another

Two Components of Trauma

- Jon Allen, Ph.D. Menninger Clinic in Houston
- Coping with Trauma: A Guide to Self-Understanding (1995)
- Subjective/Objective
- Trauma is relative
- Trauma is defined by the *experience of the survivor*

Think broadly…

- Many forms
- Significant differences among survivors
- Similarities/patterns of response

- www.sidran.org

Types of Single Blow Trauma

- Natural, i.e. weather related
- Technological, i.e. plane crash, oil spill, nuclear failure, etc.
- Criminal violence, i.e. rape, robbery, homicide

Man-Made Trauma

- War/political violence
- Human rights violations, i.e. kidnapping, torture, etc.
- Criminal violence
- Rape
- Intimate partner/DV
- Child abuse/neglect
- Sexual abuse/assault

DOSE-RESPONSE

- Best documented finding in the field of trauma work
- Higher the dose of trauma the more potential damage
- Those who have experienced repeated, intentional violence, abuse and neglect beginning in childhood
- Overwhelming grief, terror, horror, rage and anguish…all effect identity and world view

Effects most severe when:

- Human hands
- Repetitive
- Unpredictable
- Multifaceted
- Sadistic
- Begins in childhood
- Perpetrated by a caregiver

Common Emotional Responses

- Anxiety
- Social Isolation
- Anger or emotional numbing
- Sudden mood shifts
- Irritability
- Grief
- Depression
- Identity Problems
- Guilt & Shame
- Denial
- Feeling Overwhelmed
- Fear

Thought/Cognitive Responses

- Re-experiencing the trauma
- Nightmares
- Blaming Someone
- Hypervigilance
- Poor Problem Solving Ability
- Loss of Orientation
- Memory, Concentration, or Attention Problems
- Flashbacks
- Intrusive Thoughts/Images
- Poor Decision Making
- Dissociation
- Blaming Yourself

Physical Responses

- Shock Symptoms
- Dizziness
- Headaches
- Chest Pain
- Difficulty Breathing
- Muscle Tremors
- Hyper-arousal, extra sensitivity to sights, sounds, smells, touches & tastes associated with trauma event
- Fatigue
- Elevated Blood Pressure
- Profuse Sweating
- Vomiting/Nausea
- Teeth Grinding
- Somatic Disturbance

Behavioral Response

- Withdrawal
- Heightened Startle Reactions
- Increased or Decreased Appetite
- Avoiding reminders of the trauma event
- Acting Out
- Pacing the Floor
- Substance Abuse
- Homicidal or Suicidal Ideation(s)

Interpersonal Responses

- Difficulty in Forming Intimate Relationships
- Sexual Problems
- Change in Usual Communication Patterns
- Re-Victimization
- Suspiciousness

Lasting Effects

- Substance abuse and dependence
- Personality disorders
- Depression
- Anxiety (inc. PTSD)
- Dissociative disorders
- Eating disorders

PTSD

- Only d/o in the DSM that is based on etiology
- Has to be a “traumatic event”

Considerations

- “What happened to the person?” vs. “What’s wrong with the person?”
- See sx as adaptations- event may be over but the response to it is not
- What purpose does this bx serve?
- Sx like hypervigilance, dissociation, avoidance and numbing are coping strategies that help individuals *survive the* event, may interfere with living the life the cx wants to live later

Developmental Factors-Early years during personality development

Disrupts basic developmental tasks & results in mild to severe deficits in:

- Self-soothing
- Seeing the world as a safe place
- Trusting others
- Organized thinking for decision-making
- Avoiding exploitation

Possible Adaptive Behavior often "misdiagnosed"

- Disrupted self-soothing can be labeled as "agitation."
- Disrupted ability to see the world as a safe place can be interpreted as "paranoia."
- Distrust of others can be interpreted as "paranoia" even when based upon experience.

- Disruptions in organized thinking for decision-making can present like psychosis.
- Avoiding/pre-empting exploitation can be construed as a form of self-sabotage

Physiological Changes

Normal physiological responses to extreme stress lead to physiological hyper-arousal

- Hyper-vigilance, i.e. scanning, distrust, aggression & sleep disturbance
- Fight, Flight or Freeze

Other Neurobiological Changes

- Disrupted neurological development
- Difficulty controlling anger
- Hallucinations
- Depression
- Impaired memory
- Panic reactions
- Anxiety
- Multiple somatic problems
- Sleep disturbance
- Flashbacks

Oppositional Relationships vs. Therapeutic Relationships

- Power struggles
- Increase in maladaptive bx
- Decrease in cx/staff safety

- Respect
- Increase in pro-social bx
- Increase in cx/staff safety

Trauma Informed Care: Foundational Principles

- Understanding Trauma & Its Impact: seemingly ineffective bx may represent adaptive responses to past trauma

  -How might knowing this alter your approach to treatment provision?

- Promoting Safety: speaks to the establishment of emotional & physical safety; where basic needs are met, safety measures are in place and tx providers respond in consistent, predictable and respectful ways

-What would be the likely consequence at your place of employment if everyone committed to doing this

- Ensuring Cultural Competence: understanding how cultural context influence's a person's perception of & response to trauma and the recovery process
- Lesbian clients

-How might your tx approach differ if you had two cxs; one AA & one Latina both with severe DV hx

- Supporting Consumer Control, Choice & Autonomy
- How might we accomplish this?

Build competencies, outline clear expectations, keep cxs well informed, allow for self-determination (decision making), personal goals, awareness & respect for basic human rights & freedoms

- Sharing Power & Governance: promoting democracy & equalization of power across the agency; collaboration

-What do you see to be the biggest obstacle we would need to overcome in order to uphold this principle?

- Integrating Care: Maintaining a holistic view of clients and their process of healing; interagency collaboration

-To what extent is your company successfully doing this? Can the way you are currently doing this be improved?

- Healing Happens in Relationships: Believing that establishing safe, authentic, and positive relationships can be corrective and restorative to survivors of trauma

-What barriers can you identify that impede your ability to build this type of “therapeutic alliance” with cxs?

- Recovery *is* possible: Recovery is possible for EVERYONE regardless of how vulnerable they may appear; instillation of hope, facilitating peer support, focusing on strengths/resiliency and establishing future-oriented goals

-How might our current conception of “recovery” limit our clients success?

Trauma-Informed Treatment Milieu

- Facilitate the development of therapeutic alliances/relationships
- Collaborative/empowering by design
- Establish “safety” as number one priority
- Serve as *corrective experience* for the population served

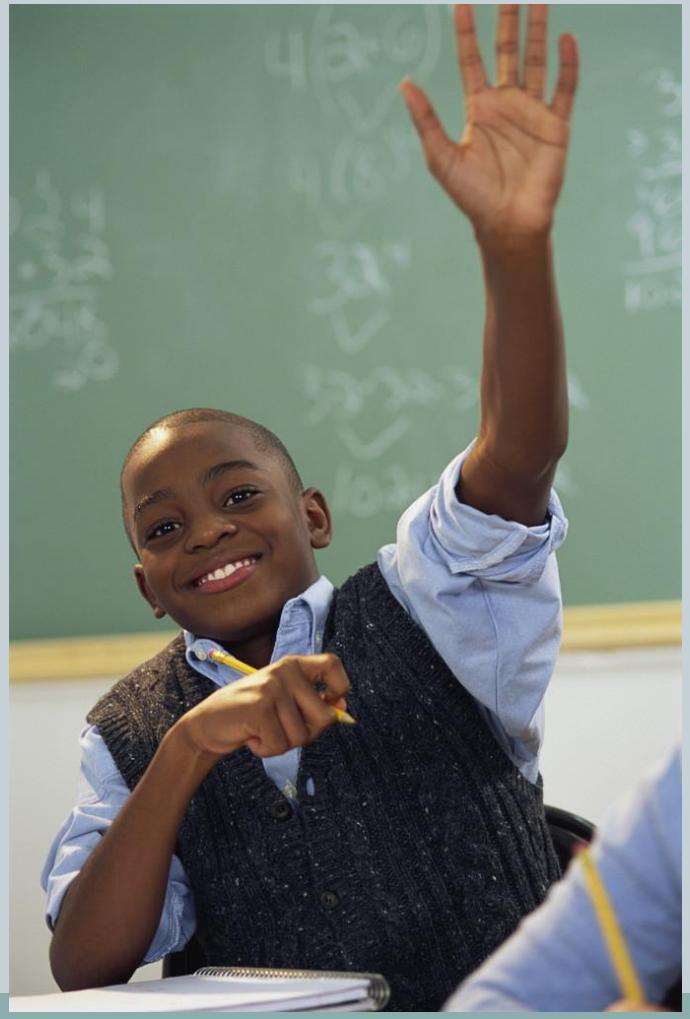
References

- Courtois, Christine A. Understanding Complex Trauma, Complex Reactions, and Treatment Approaches. See www.thegiftwithin.org
- Giller, Esther. What is psychological trauma? See www.sidran.org
- Finkelstein, Norma et al. Enhancing Substance Abuse Recovery Through Integrated Trauma Treatment. See The National Trauma Consortium

References Cont'd

- Trauma Informed Care: A Guide for Service Providers; Women's Bureau, Department of Labor

Any Questions?



Thank You!

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