Trauma-Informed care

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The Tavistock Trauma Service

Definition of Trauma-informed Care

Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.

Hopper, Bassuk & Olivet 2010

Trauma – informed care

TIC versus trauma-specific services – an approach not a treatment

SAMHSA – Substance Abuse & Mental Health Administration's 4 assumptions and 6 principles

Arose out of recognition of complexity and intersectionality – substance misuse & mental health, disenfranchised, low-income, ethnic minority women

-exposure to an extremely threatening or horrific event or series of events in which escape is difficult or impossible.

ICD 11

An inescapably stressful event that overwhelms people's existing coping mechanisms. Bessel van der Kolk (1996)

-That which causes dissociation, rooted in helplessness Elizabeth Howell (2020)

-The inability to integrate the implications of an event into the existing conceptions of oneself and the world Moskowitz 2019

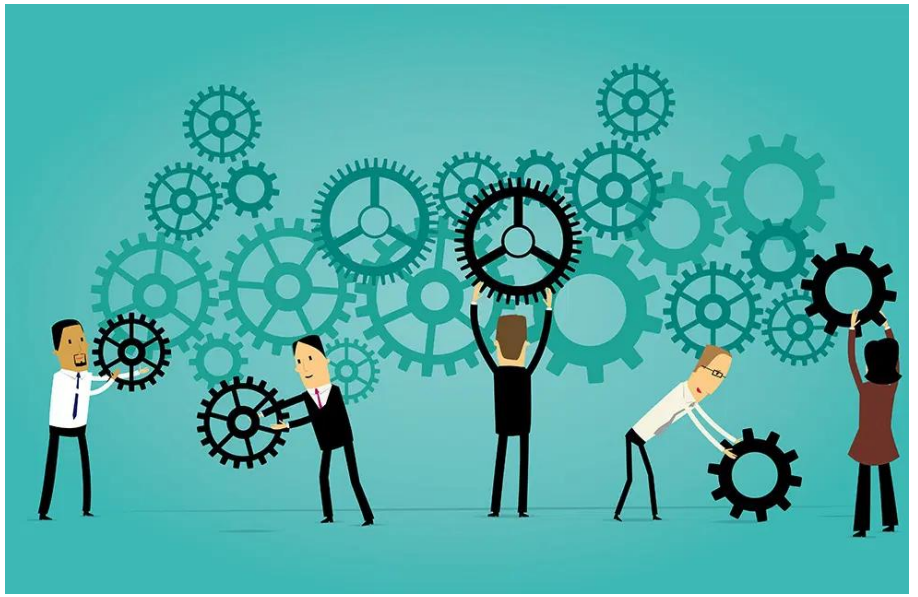
- An experience becomes traumatic only when it leads to a feeling that one's mind is alone. Allan 2012

A relational experience in that embedding of trauma may arise not primarily from the nature of events but from who is with us before, during and after. Badenoch 2017

Trauma definitions

The core experiences of psychological trauma are disempowerment and disconnection from others

Herman, 1997



TRAUMA-INFORMED CARE

TRAUMA INFORMED CARE

”What is wrong with you?”

”What happened to you?”


Safety
Trustworthiness and Transparency
Cultural, historical, and gender issues
Trauma Informed Care 6 Core Principles
Peer support and mutual self-help
Empowerment, voice, and choice
Collaboration and mutuality

TIC questions

What does this person need to feel safe?

How can I demonstrate my trustworthiness?

How can I empower this person in their treatment?

How do I support a position of collaboration with this person?

What might I need to consider in relation to our different backgrounds?

How might I include peer supporters / experts by experience in their treatment plan?

TIC QUESTIONS - ORGANIZATIONAL

- Is there robust leadership that supports TIC principles?
- Do all policies and procedures align with TIC principles?
- Is lived experience represented across the organization?
- Are processes transparent and well-communicated to staff and patients?
- Is the physical work environment welcoming, clean, calming and free from obvious triggers?
- Does leadership invite and value input from all levels of the organization?
- Are services adapted to be culturally relevant and inclusive?

Survivor involvement

Engagement at different levels

Peer supporters embedded within services

Co-design

Co-production

Co-delivery

The Four Rs of Trauma-Informed Care

Realize the widespread impact of trauma and understand potential paths for recovery

Recognize the signs and symptoms of trauma in clients, families, staff, and others involved with the system

Respond by fully integrating knowledge about trauma into policies, procedures, and practices

Resist re-traumatization of children, as well as the adults who care for them

This figure is adapted from: Substance Abuse and Mental Health Services Administration. (2014). SAMHSA's concept of trauma and Guidance for a trauma-informed approach. HHS publication no. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Realize & Recognize

Prevalence of trauma & adverse childhood experiences (ACEs)

Neurobiological impact of trauma

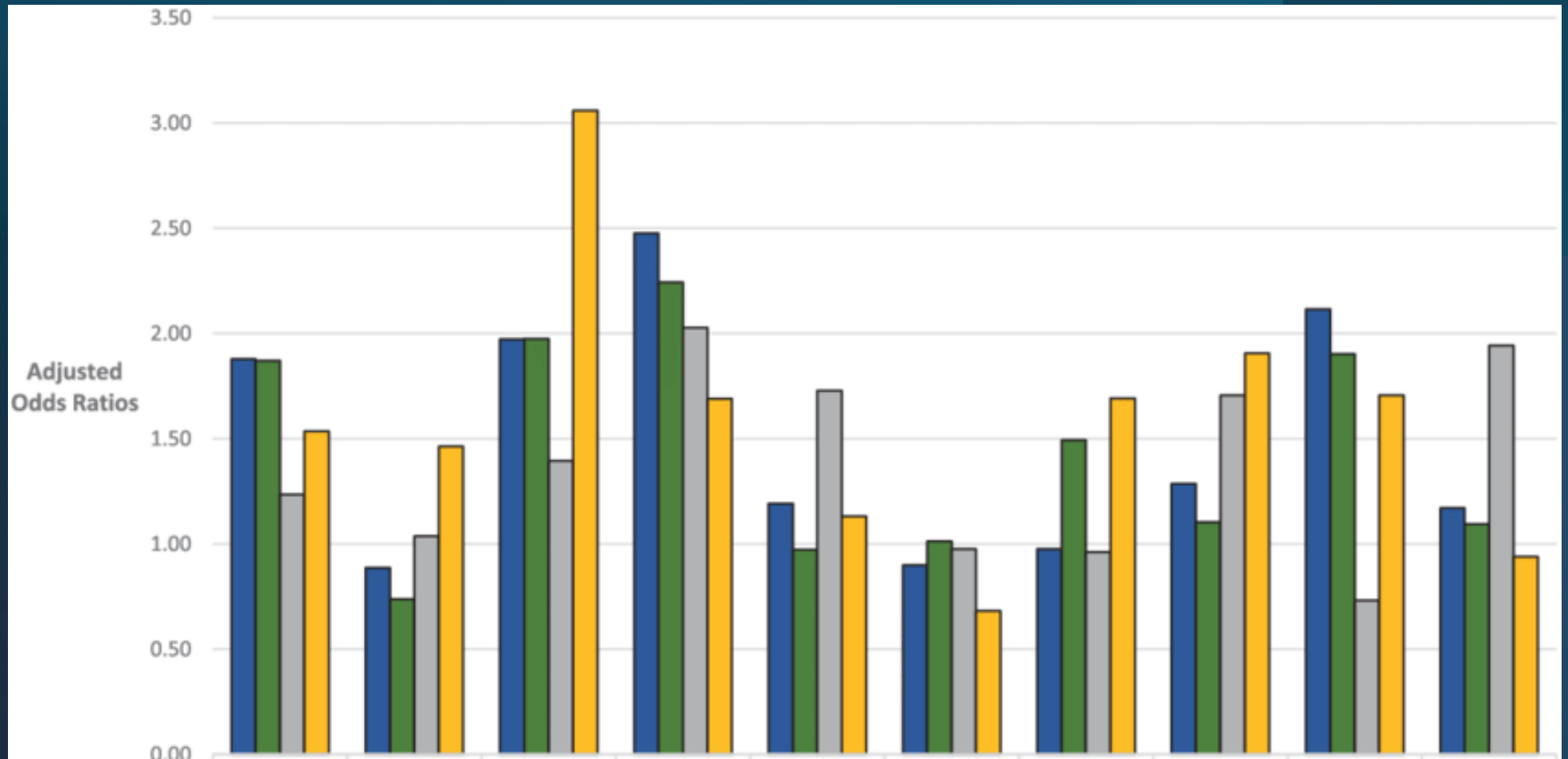
Broader view – community, society, historical, cultural aspects to trauma

Individual and organizational defenses against realizing and recognizing trauma

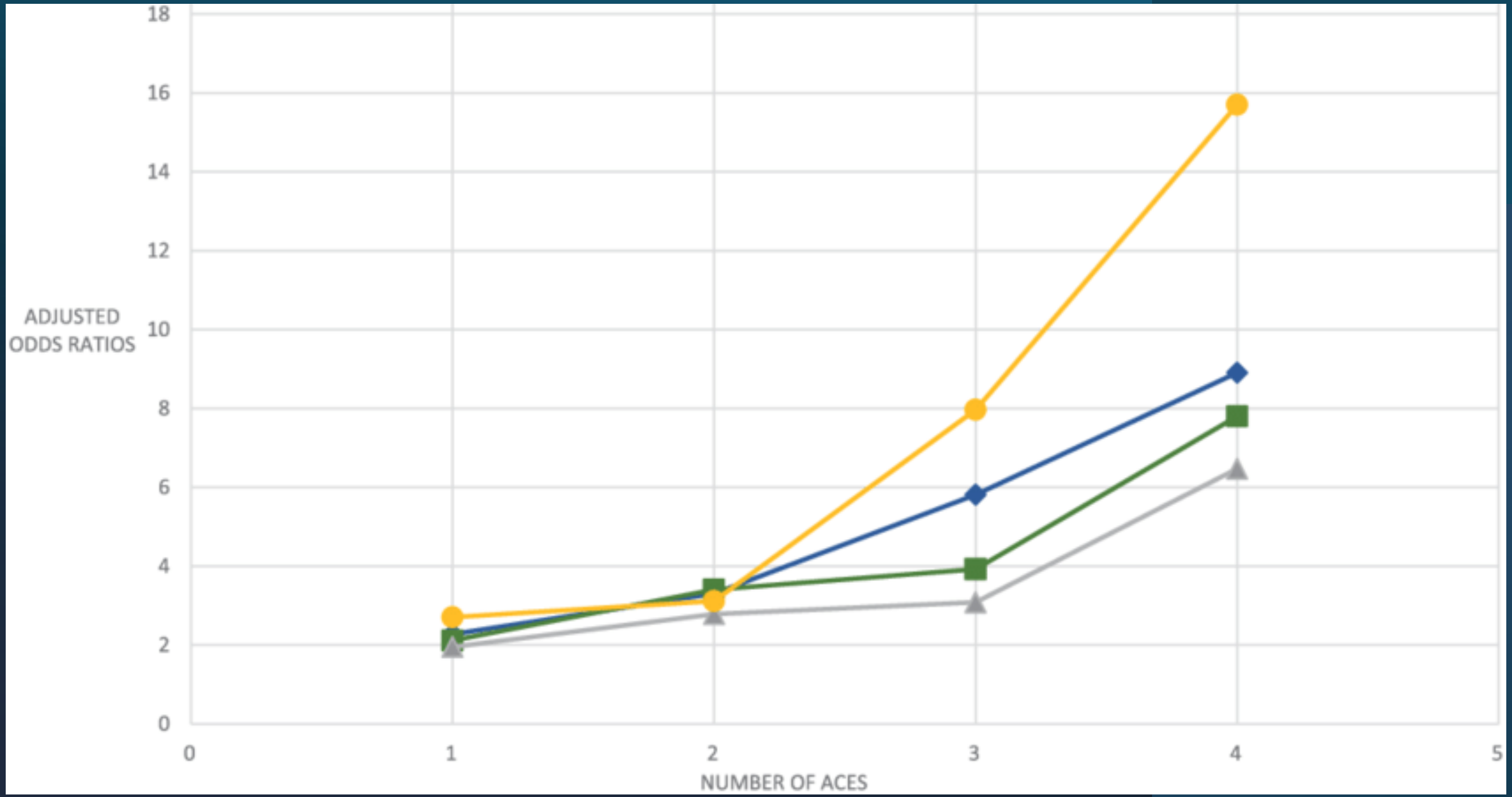
Issues that may make disclosure difficult

Using a biopsychosocial formulation

Abuse	Neglect	Household Challenges	
 PHYSICAL	 PHYSICAL	 MENTAL ILLNESS	 INCARCERATED RELATIVE
 EMOTIONAL	 EMOTIONAL	 MOTHER TREATED VIOLENTLY	 SUBSTANCE ABUSE
 SEXUAL		 DIVORCE	



	Verbal Abuse	Physical Abuse	Sexual Abuse	Emotional Neglect	Physical Neglect	Separated/ Divorced	Witness Domestic Violence	Problem Drinker	Mentally Ill/Attempt Suicide	Prison
Depression	1.88	0.89	1.97	2.48	1.19	0.90	0.98	1.29	2.12	1.17
GAD	1.87	0.74	1.98	2.24	0.97	1.01	1.49	1.10	1.90	1.10
PTSD	1.24	1.04	1.40	2.03	1.73	0.98	0.96	1.71	0.73	1.94
CPTSD	1.54	1.46	3.06	1.69	1.13	0.68	1.69	1.91	1.71	0.94


ADJUSTED ODDS RATIOS
18
16
14
12
10
8
6
4
2
0
0
1
2
3
4
5
NUMBER OF ACES

The Pair of ACEs

Adverse Childhood Experiences

Maternal Depression

Physical & Emotional Neglect

Emotional & Sexual Abuse

Divorce

Mental Illness

Substance Abuse

Incarceration

Domestic Violence

Homelessness

Adverse Community Environments

Poverty

Violence

Discrimination

Poor Housing Quality & Affordability

Community Disruption

Lack of Opportunity, Economic Mobility & Social Capital

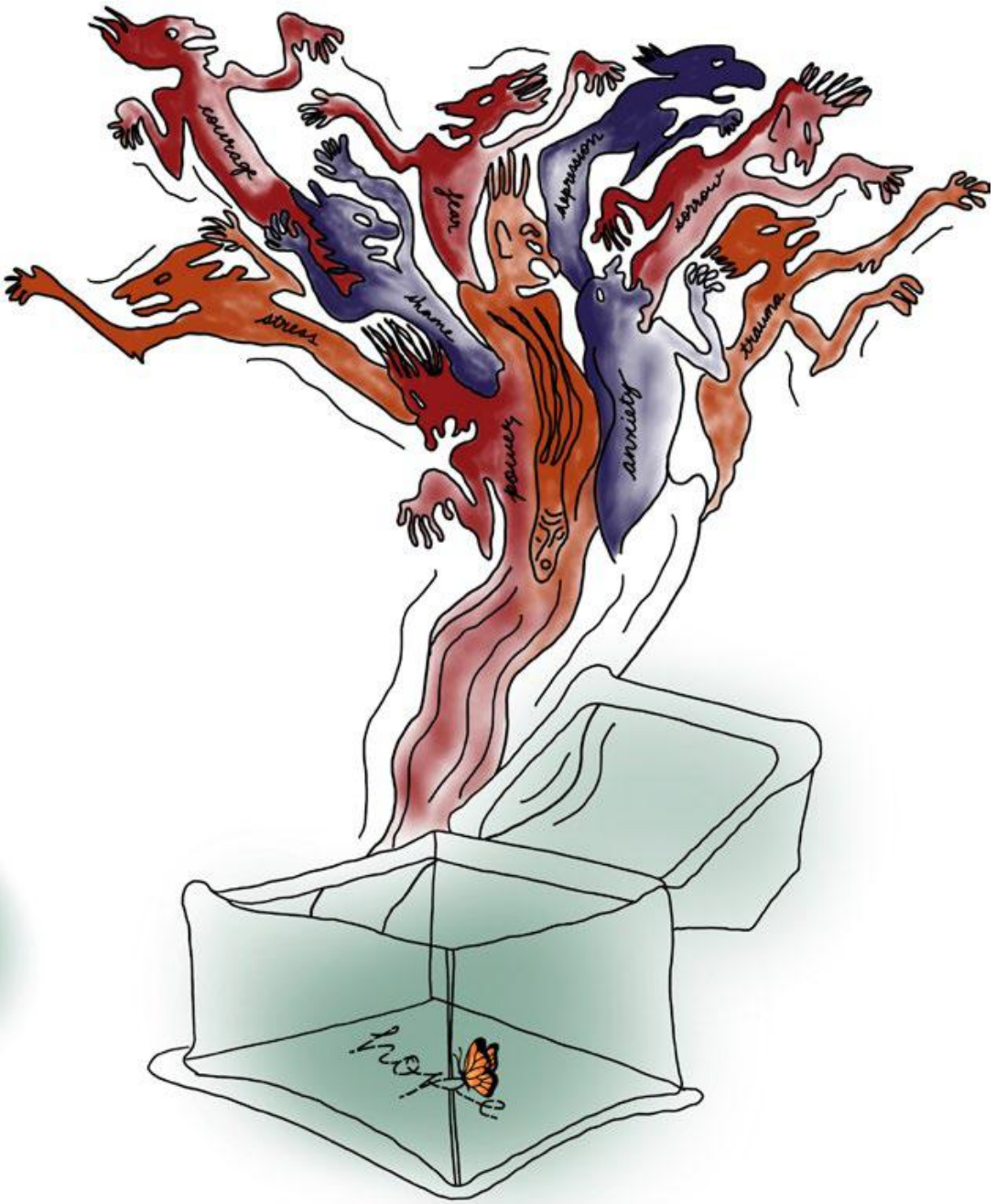
Prevalence of Child Sexual Abuse

- One in six girls and one in 20 boys in England and Wales (IICSA)
- 3.1 million adults aged 18-74 years experienced sexual abuse before the age of 16 (ONS 2020)
- 500 000 children experience some form of sexual abuse each year (CSA Centre 2022/23)
- 50-60% of inpatients and 40-60% adult outpatients in MH had experienced sexual violence and / or sexual abuse (Hughes et al 2019 & Cross Gov Action Plan on Sexual Violence and abuse 2007)


Physical health
• Physical injuries
• High BMI
• Problems related to childbirth
• Unexplained medical problems
Emotional wellbeing, mental health and internalising behaviours
• Emotional distress
• Trauma/ PTSD
• Anxiety
• Depression
Externalising behaviours
• Substance misuse
• 'Risky' and inappropriate sexual behaviours
• Offending
Interpersonal relationships
• Reduced relationship satisfaction and stability
• Issues with intimacy and parent-child relationships
Socio-economic
• Lower educational attainment
• Higher unemployment
• Financial instability
• Homelessness
Religious and spiritual belief
• Disillusionment with religion
• Faith as a coping mechanism
Vulnerability to revictimisation
• Sexual revictimisation in childhood and adulthood
• Other types of victimisation

Link to Psychiatric Diagnoses and Treatment

- NRCSA impacts on mental health service usage (Cutajar et al 2010 – NRCSA 3.65x more likely)
- NRCSA increases population attributable risk (Fergusson et al 2008 PAR 13.9%)
- Higher rates of depression, anxiety, PTSD, complex PTSD psychotic disorders, substance misuse disorders, eating disorders and dissociative disorders in NRCSA survivors.
- CSA is strongest independent risk factor for CPTSD



Disclosures

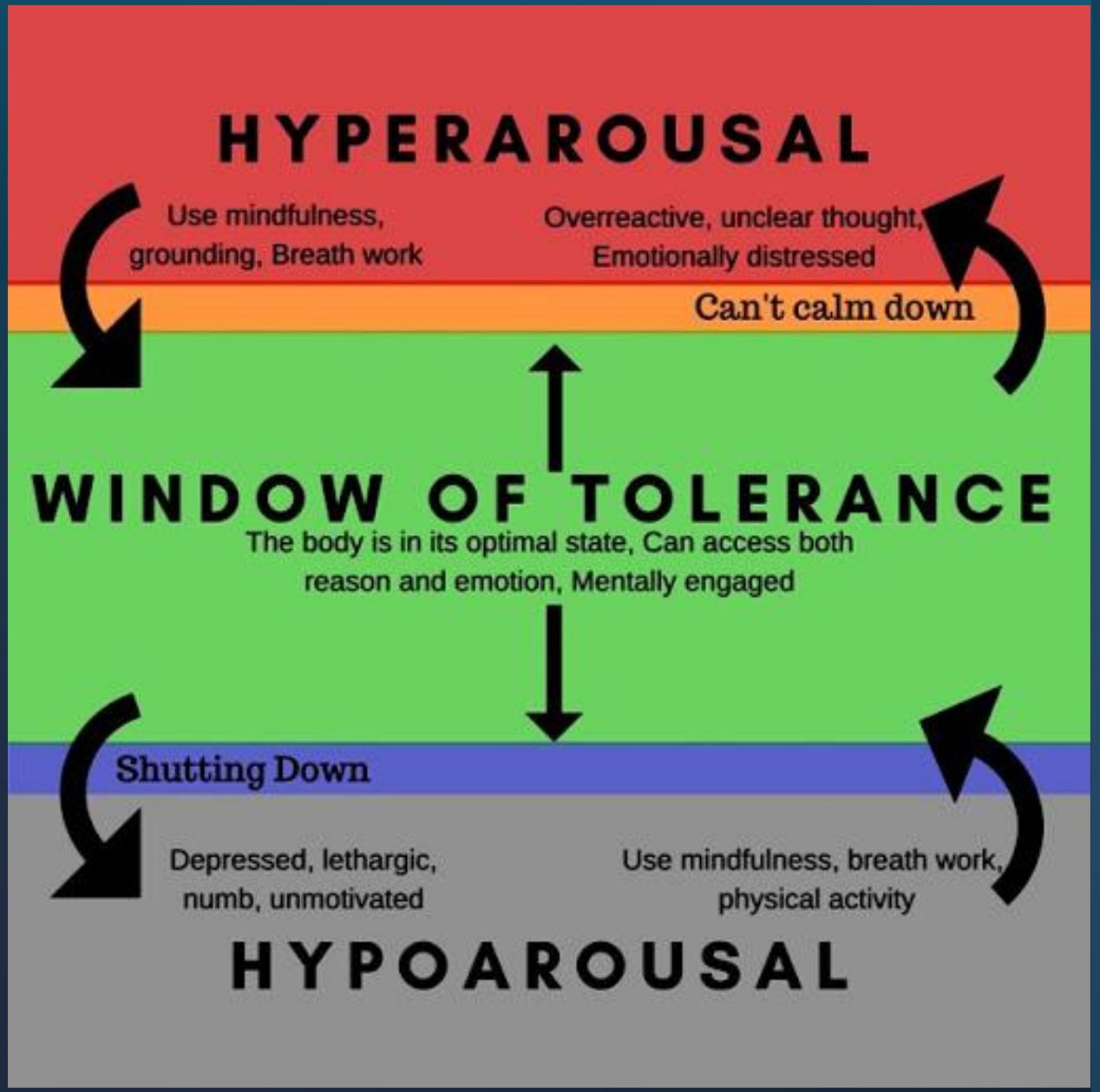
- Many people do not disclose at the time of the abuse.
- Average time to disclosure 16-24 years (IICSA 2022)
- 60% survivors delayed disclosure for 5 years or more (London et al 2008)
- 1 in 5 survivors reporting never having disclosed to anyone (Hebert et al 2009)
- Only 20% of survivors report being asked in MH services (Reid et al 2016)

Disclosure – what stops us?

- Focus on immediate concerns
- Fear of causing distress
- Fear of vicarious traumatization
- Prioritizing a bio-medical model
- Lacking training
- Anxieties about time / resources / paperwork
- Not knowing enough about safeguarding / signposting etc

Safety

- Trustworthiness and transparency
- Therapeutic engagement
- Physical setting
- Organizational processes
- Resourcing


HYPERAROUSAL
Use mindfulness, grounding, Breath work
Overreactive, unclear thought, Emotionally distressed
Can't calm down
WINDOW OF TOLERANCE
The body is in its optimal state, Can access both reason and emotion, Mentally engaged
Shutting Down
Depressed, lethargic, numb, unmotivated
Use mindfulness, breath work, physical activity
HYPOAROUSAL

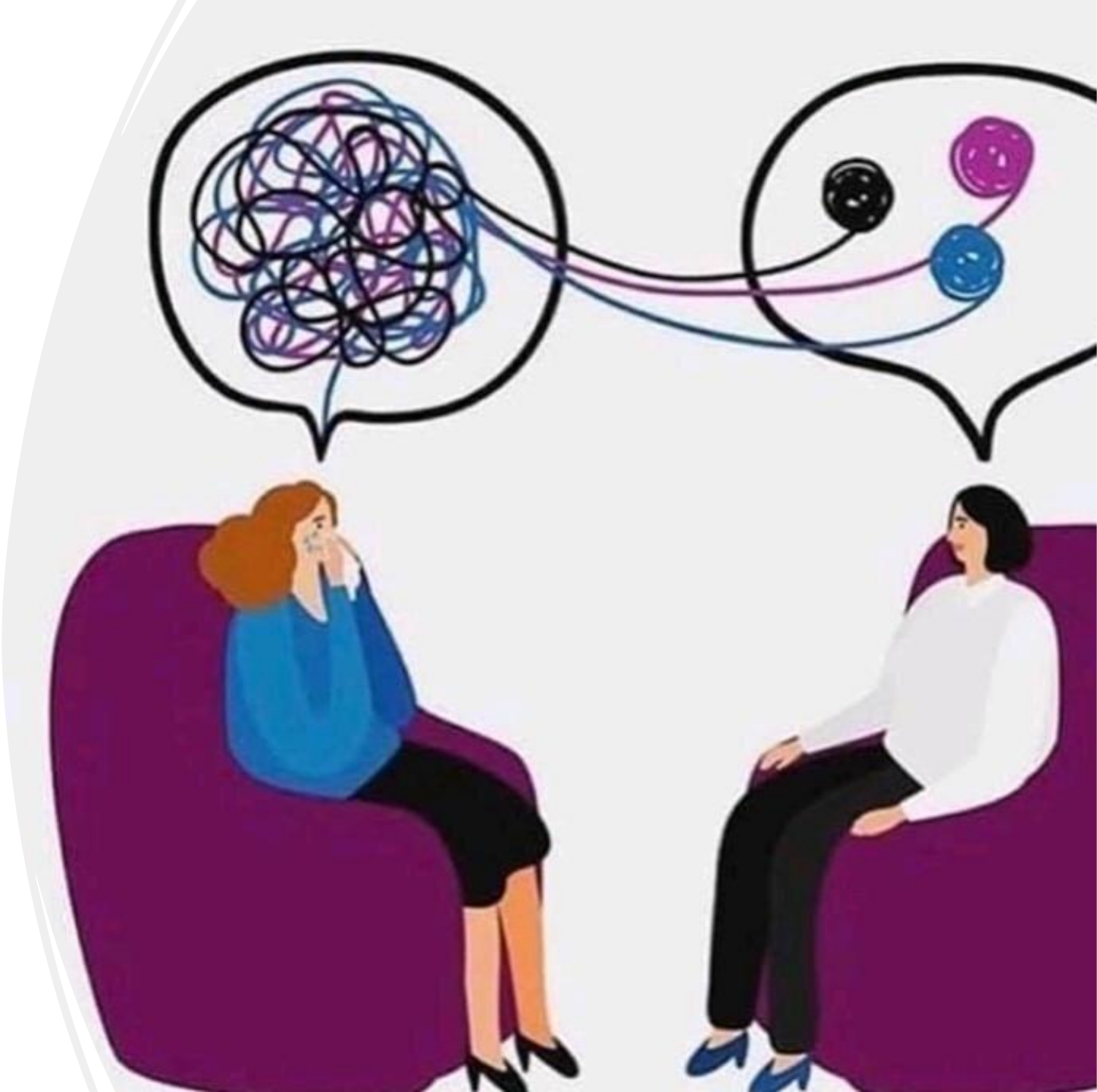
Power dynamic

No intervention that takes power away from the survivor can possibly foster her recovery, no matter how much it appears to be in her immediate best interest.

Herman 1998

Power dynamic

- “working alongside”
- Psychoeducation
- Transparency
- Resourcing
- Choice and voice
- Survivor involvement



Awareness of social, cultural and historical traumas

Racism

Poverty

Colonialism

Disability

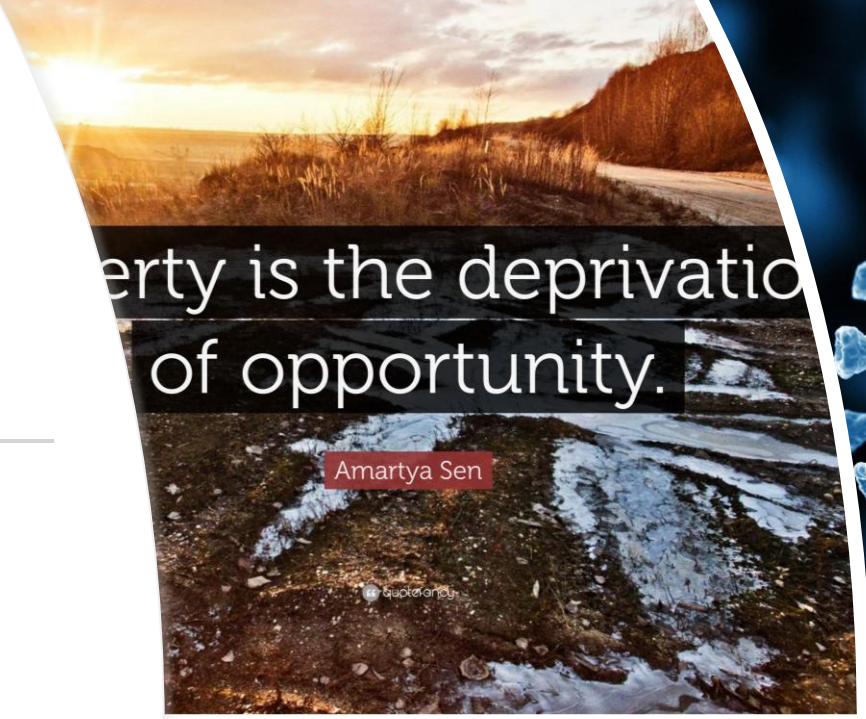
Homophobia

Transphobia

Sexism

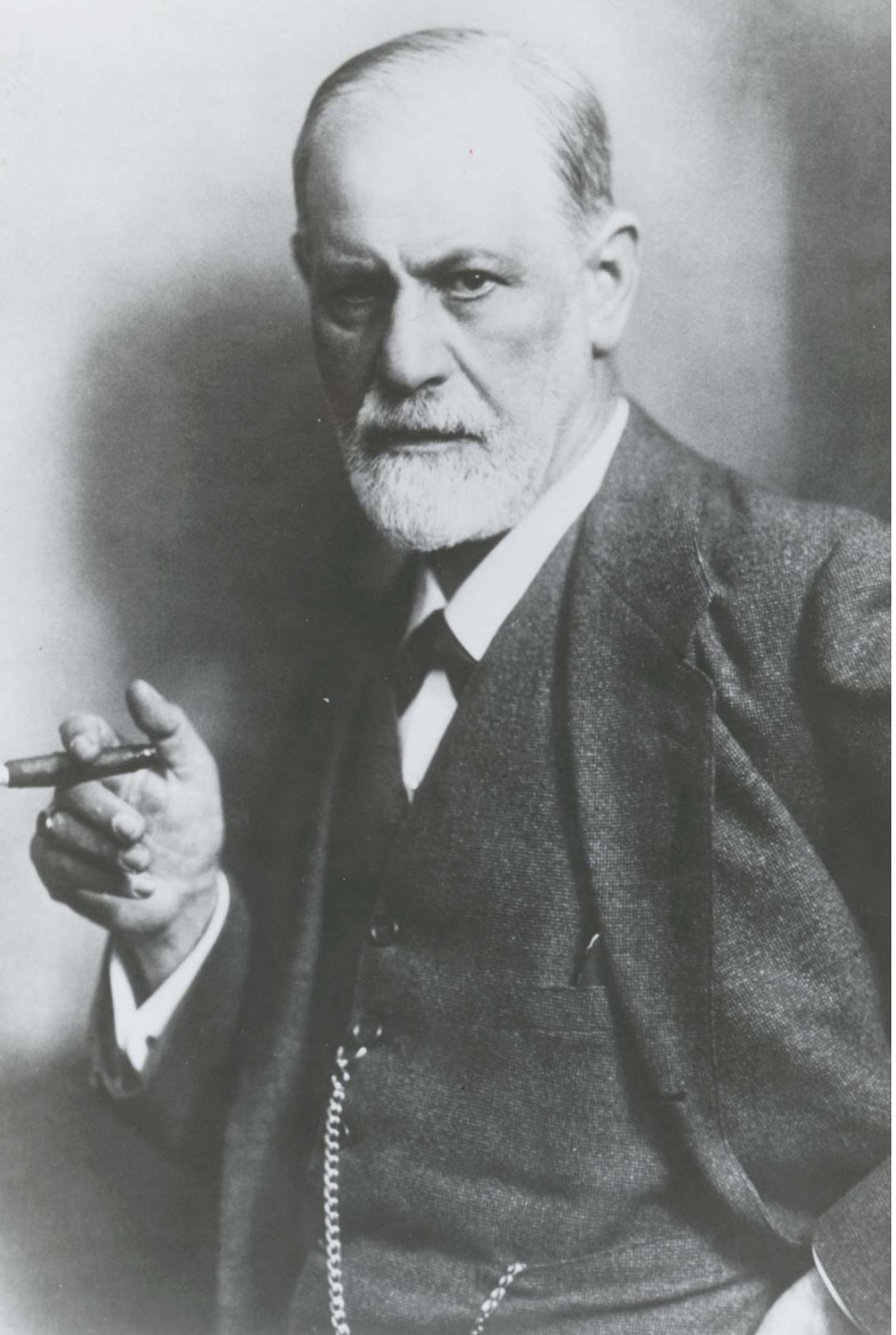
Where we are now

- Austerity impact
- Covid 19 and its impact
- Black Lives Matter
- Climate Change
- Growing social inequality and deprivation
- Limited resources
- Insufficient funding to mental health services




GRRAACCEESS
Gender
Race
Religion
Age
Ability
Class
Culture
Education
Ethnicity
Sexuality
Spirituality

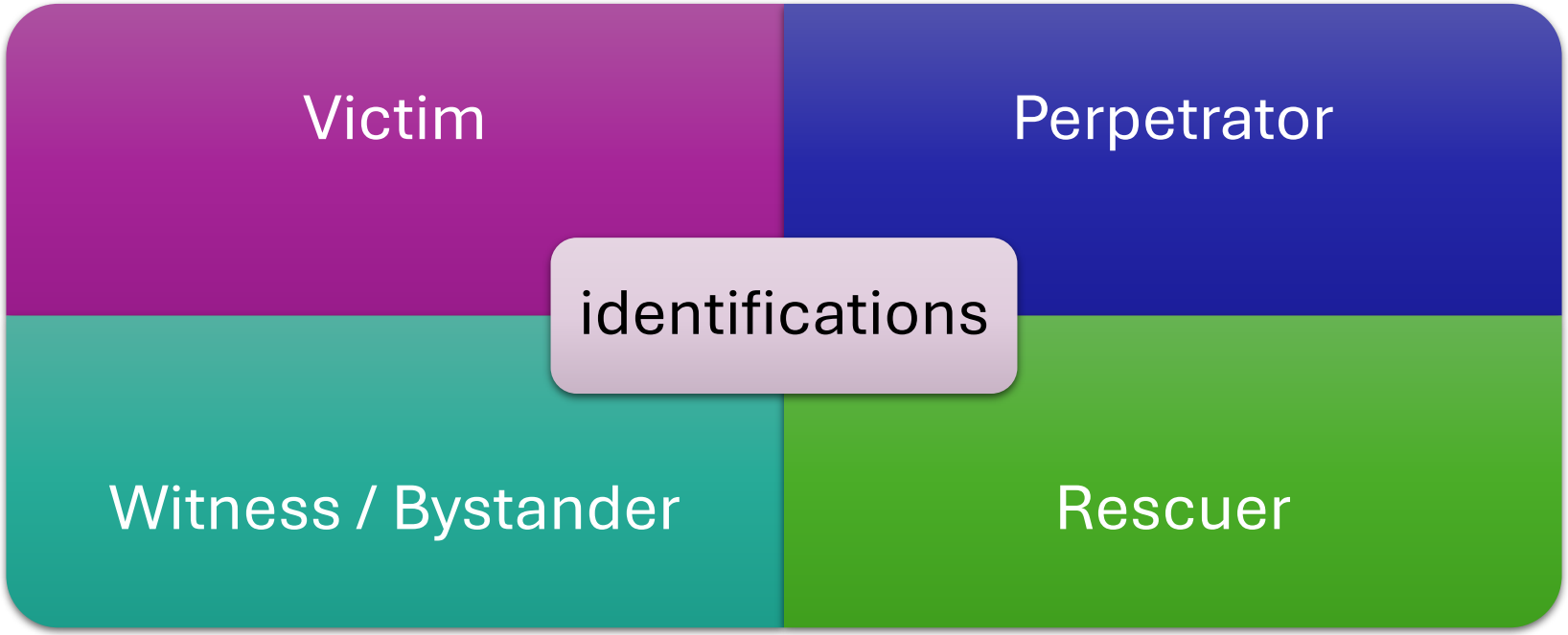
Prevent re-traumatisation



The Repetition Compulsion

If a person does not remember, he is likely to act out, he produces it not as a memory but as an action; he repeats it, without knowing, of course, that he is repeating, and in the end, we understand that this is his way of remembering.

Freud 1920


Victim
Perpetrator
identifications
Witness / Bystander
Rescuer


UNDER-
INVOLVED
ZONE OF
HELPFULNESS
OVER-
INVOLVED

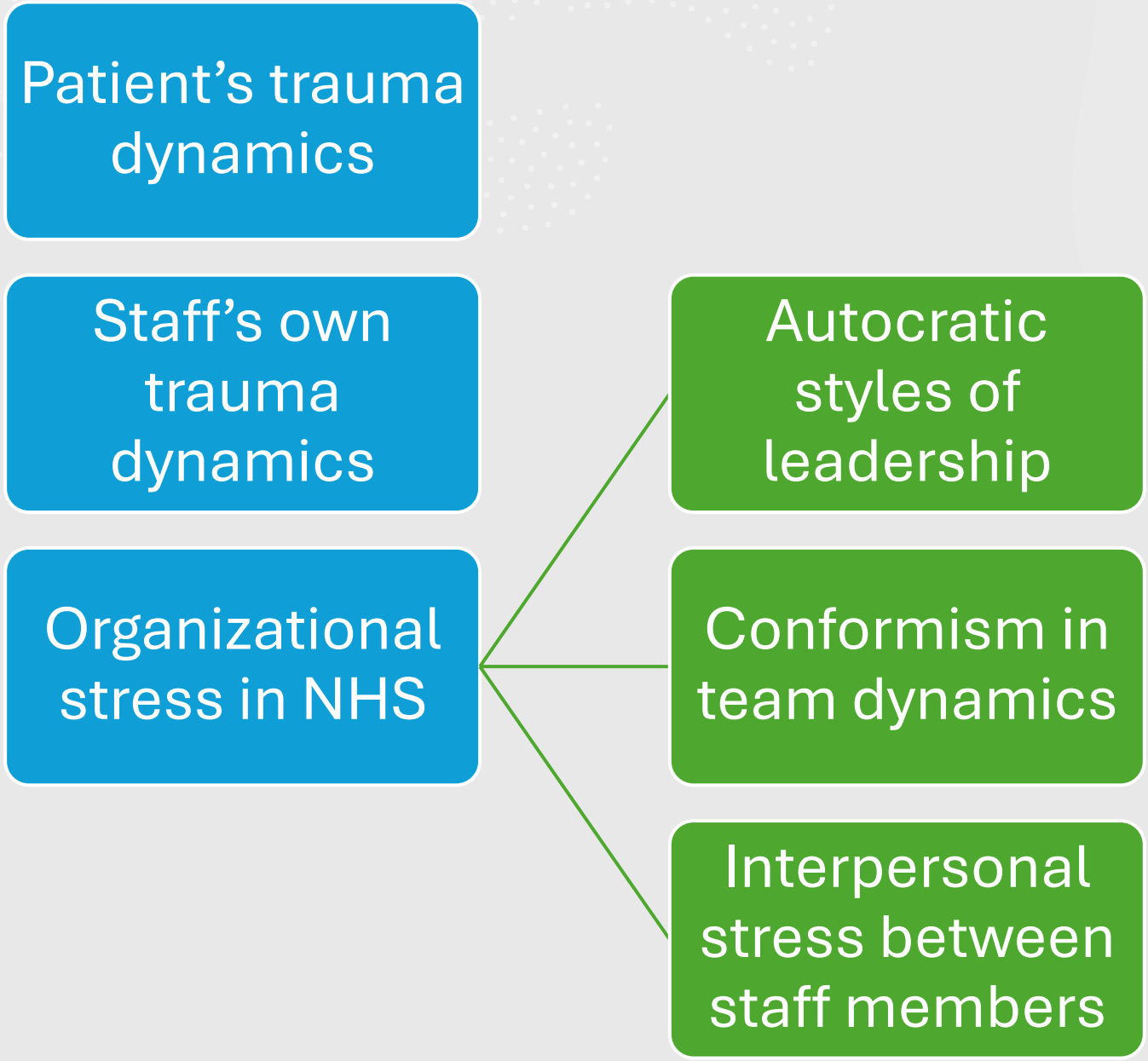
Working with trauma

- Repetition of traumatic scenario – Victim, perpetrator, witness or rescuer
- We are invited unconsciously to take up one of these roles
- We can all get pulled into the repetition - victim, perpetrator, witness or rescuer

Working with trauma

- This can make us do things we wouldn't usually do → boundary issues or cause pain and distress
- Being aware that this is likely to happen and being able to find a way to think about and reflect on it will help to find a way out
- Reflection – spaces to think and talk
- Self-care – supported by organizational policies

Re-traumatisation



What do we need to work with our patients and in our organizations?

- We need time to think and notice experiences in the work
- We need to feel supported and safe in the work
- We need good communication across the organization
- We need to feel heard
- We need opportunities to connect with colleagues
- We need to be supported in speaking openly about experience
- We need to be able to do the things we enjoy and to feel restored

What happens when we don’t have this

- Burnout
- Compassion stress and fatigue
- Moral injury and institutional betrayal
- Vicarious Traumatization

You aren’t pleased or excited to go to work

You talk only about work and have no other interests

You treat everyone like a client

You dream about work especially bad dreams

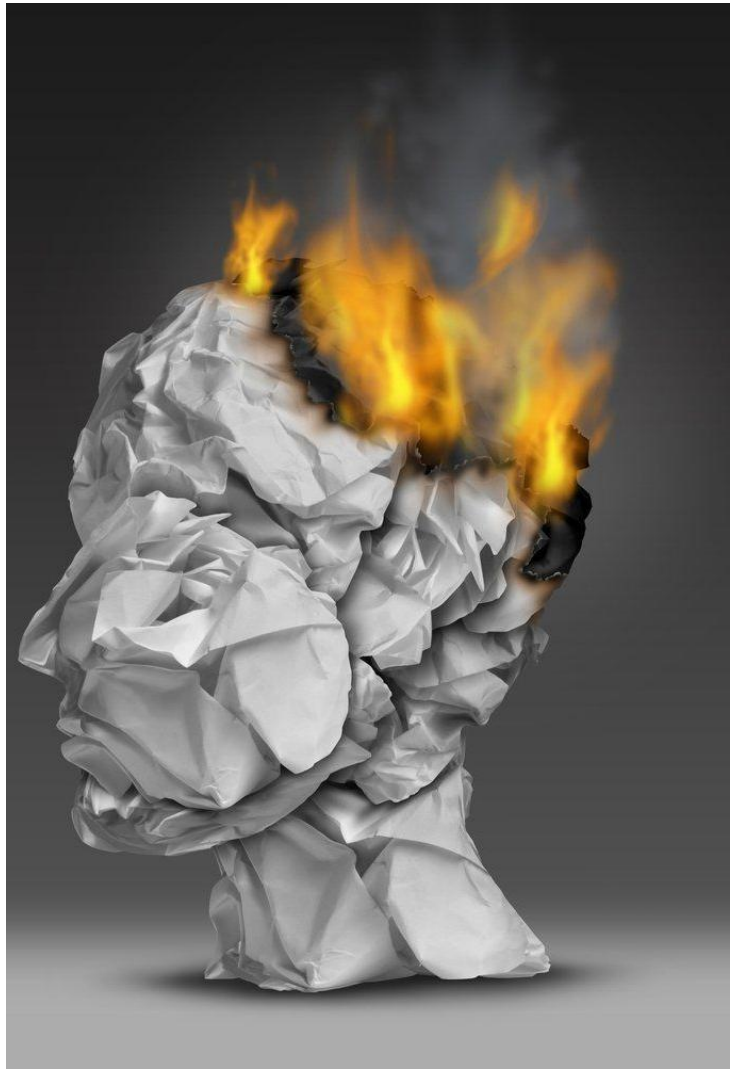
You feel shame for your human limitations

You have secondary trauma reactions – flashbacks, anxiety, depression or avoidance around work

You want to drink, gamble or otherwise dissociate after work

Vicarious traumatization- the organization

- Widespread cynicism and pessimism
- Increased illness or absenteeism
- ”Presenteeism"
- Ethical or boundary violations
- Grievances and complaints
- Reductions in motivation and productivity
- Higher staff turnover
- Decrease in staff morale




Social Support
Positive Emotions
Coping
Meaning in Life
Resilience
Physical Well-Being
Resilience Model
GEORGE MASON UNIVERSITY

Staff Wellbeing

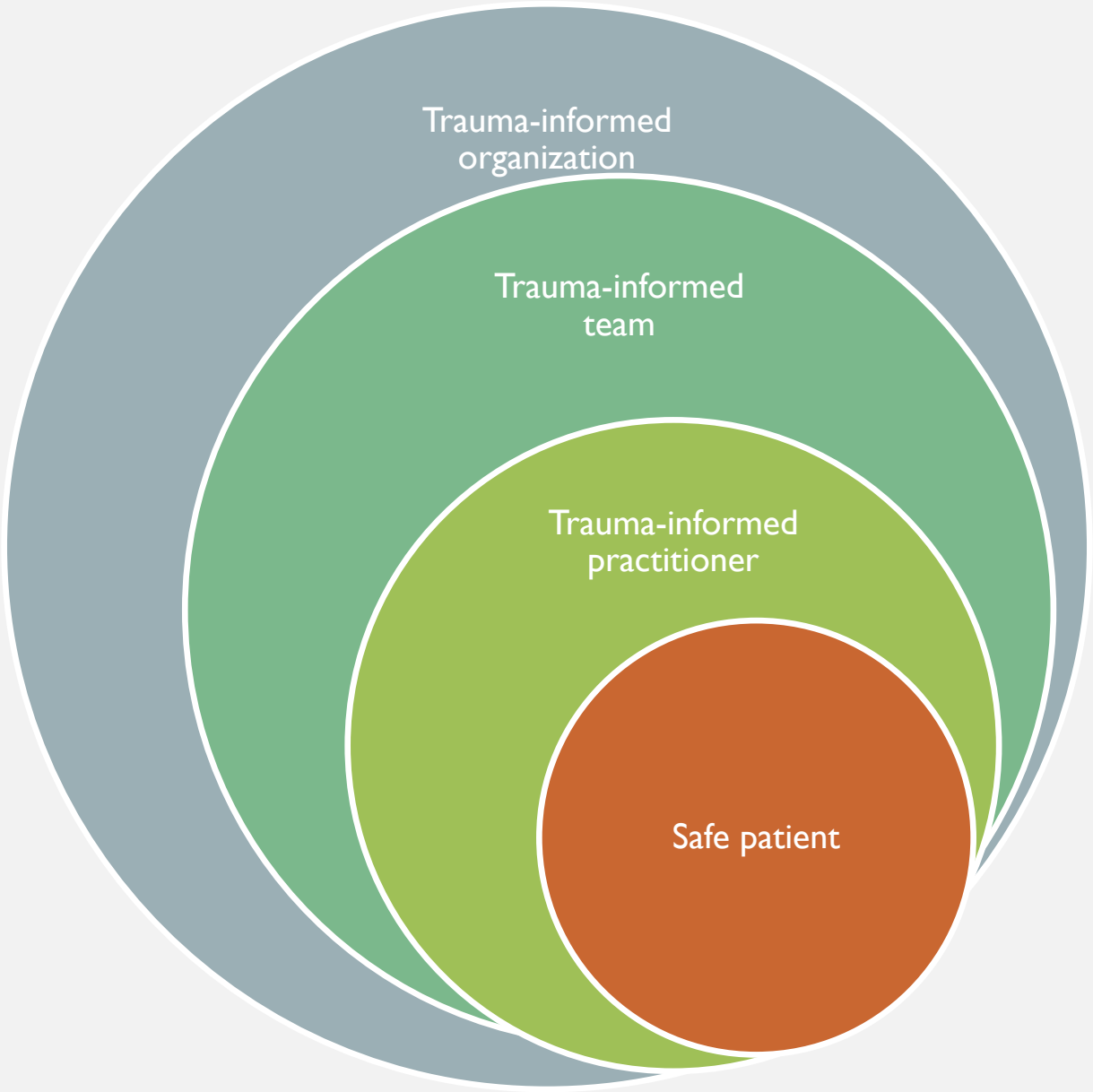
“What do you need to do your job well?”

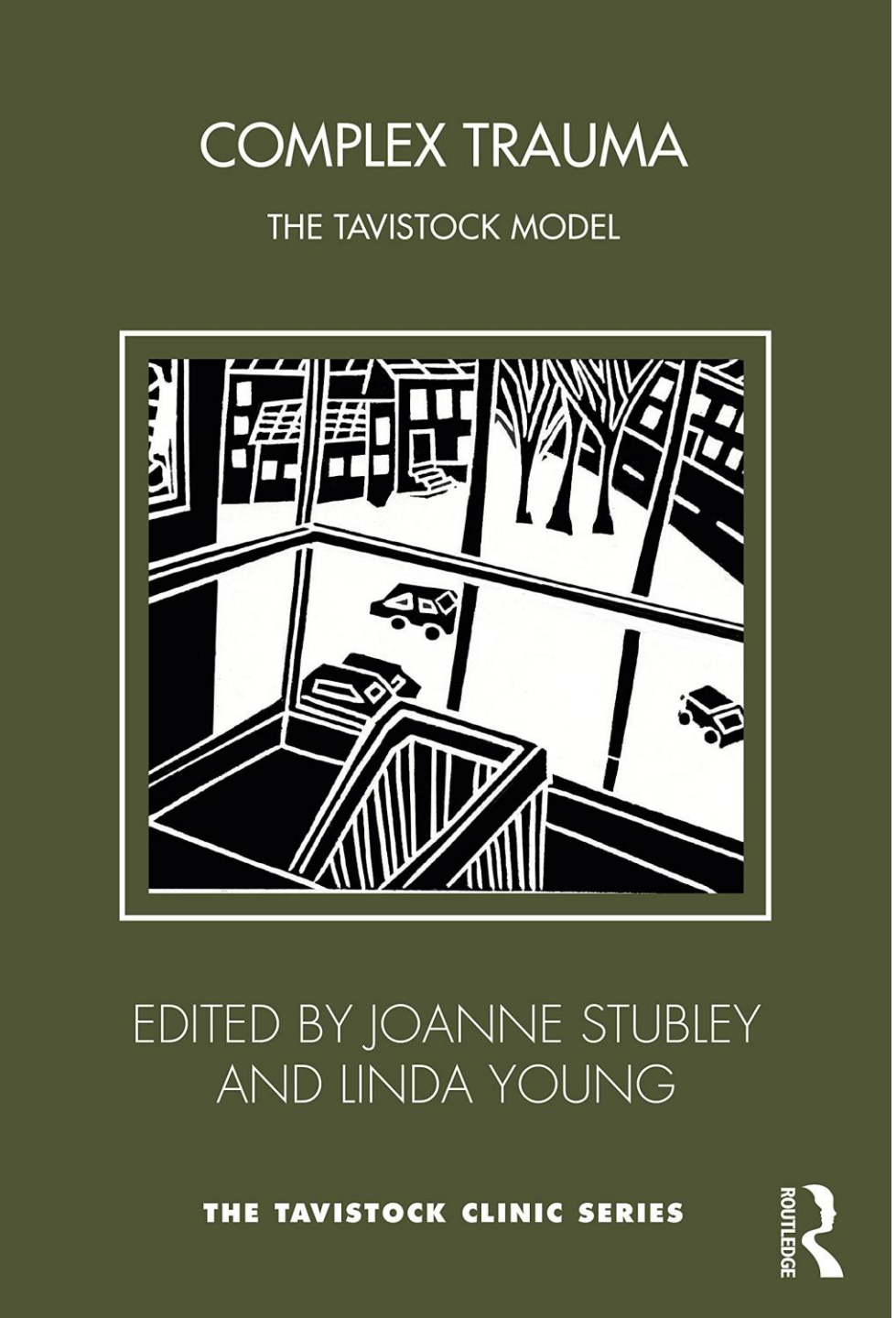
REFLECTIVE SPACES

- Opportunities to think about the impact of working with traumatized individuals
- Shifting what might be held in the body into thoughts and then words to others
- Processing the emotions that have been activated

GOOD LEADERSHIP

Wellbeing	Acknowledgement	Communication	Support team cohesion
Attend to physical and emotional safety of staff Model good self care Promote wellbeing initiatives	Stress and trauma Moral dilemmas Hard work and success Moral injury as organizational decisions	Accurate updates Open and honest Provide mechanisms for feedback Validate and normalize distress	Safe spaces Peer support and buddy systems Share difficult decisions


Trauma-informed organization
Trauma-informed team
Trauma-informed practitioner
Safe patient



Thank you

Contact Jo Stubley

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https://tavistockandportman.ac.uk/courses/child-sexual-abuse-disclosure-how-to-support-adult-survivors-daa019/