The information in this presentation is current as of the published date noted below and is subject to change.

Trauma Informed Care for Providers

Integrating Trauma Informed Care and Resilience Informed Practices

Last Reviewed January 2025

Agenda

- Trauma & Resilience Informed Practices
- Adverse Childhood Experiences Study (ACES)
- Trauma and Stress-Related Disorders and Different Types of Trauma
- Other Trauma- and Stressor-Related Disorders
- Understanding Resilience
- Tips: Trauma Informed Practices that Build Resilience
- Resources

Trauma & Resilience Informed Practices

What is Psychological Trauma?

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.

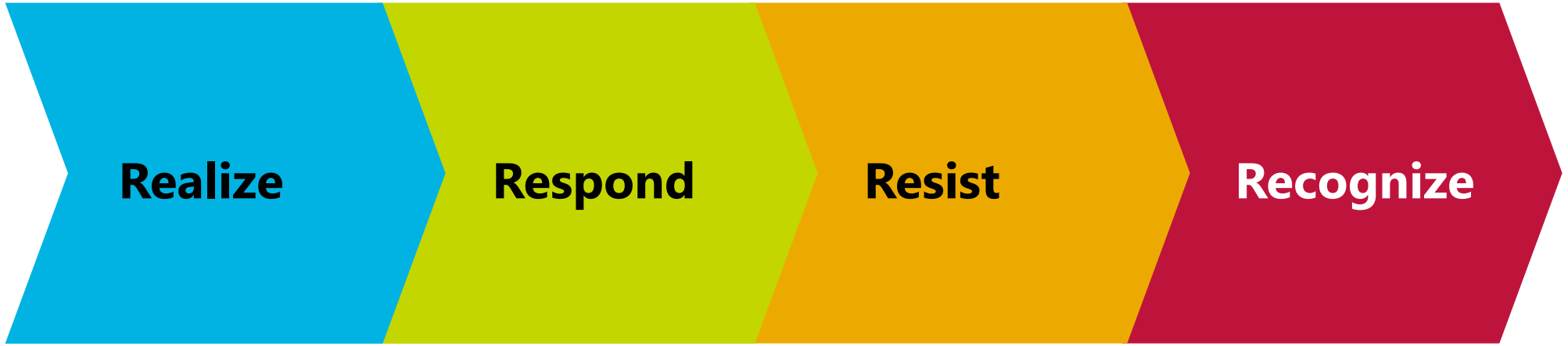
SAMSHA definition of trauma includes three key elements:

- External cause (event or circumstances)
- Individual life changing experience
- Profound effects

The combination of one or more adverse events that results in long lasting emotional, cognitive and/or physical harm.

4 R's of a Trauma Informed Approach

- **R**ealizes the prevalence of trauma
- **R**esponds by putting this knowledge into practice
- **R**esists re-traumatization
- **R**ecognizes the impact of trauma on recipients of services and providers



Reference: SAMHSA

The Concept of “Universal Precautions”

- We don’t know what kinds of experiences our participants have had when they present for services, so:
  - If we assume it is not related to trauma, then we miss a great opportunity to help
  - If we assume trauma may be playing a role then we begin to pay attention to signs of trauma and ask the right questions
- The steps we take to create a safe and trusting environment benefits everyone
- A trauma-informed approach is designed to avoid re-traumatizing those who seek assistance

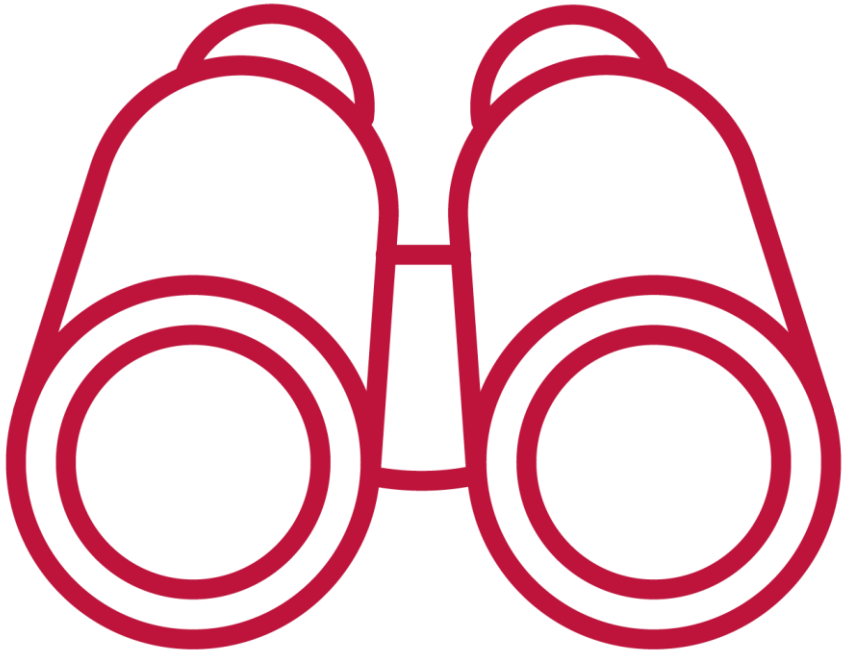
3 Pillars of Trauma Informed Care

- ✓ Safety
- ✓ Emotion Regulation
- ✓ Relationships

Why focus on trauma?

- Research on trauma has evolved over time
- The Trauma Informed Care (TIC) movement picked up Adverse Childhood Events (ACEs)
- ACEs and trauma are more prevalent in human service systems (e.g. behavioral health, child welfare, and homeless programs)
- ACEs and trauma can be difficult to detect

Bottom line: service providers who understand trauma and its effects can avoid or prevent re-traumatizing people who receive services



Resilience Definition

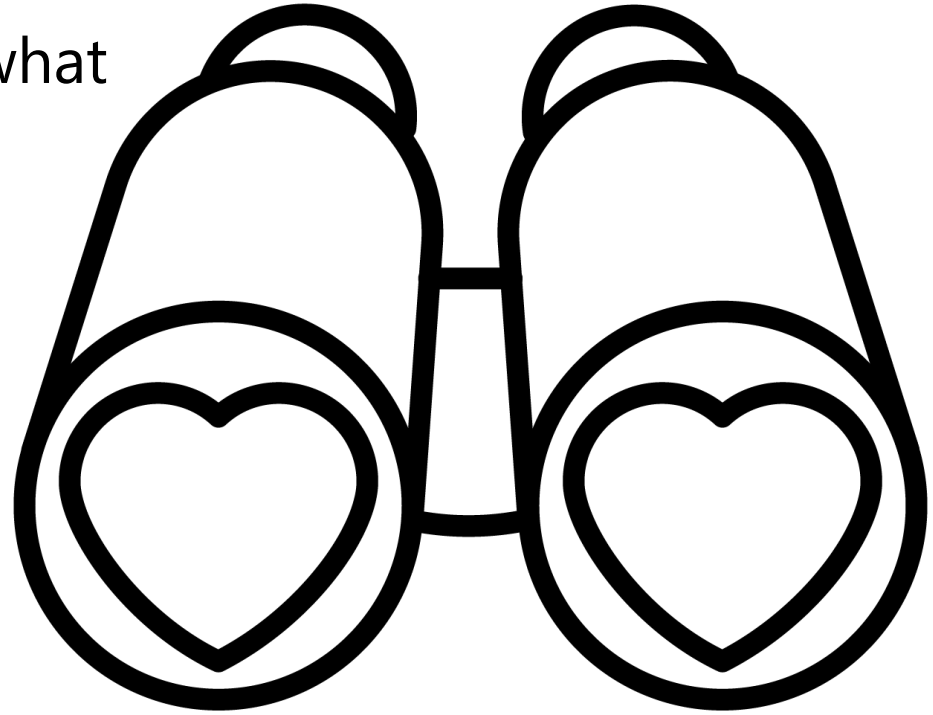
A dynamic process reflecting positive adjustment despite significant risk or adversity.

- **Adversity** – experiences with high probability for negative outcomes.
- **Positive adaptation** – better than expected life outcomes despite being exposed to adversity.

References: Luthar, Garmezy, Rutter

Why focus on resilience?

- Resilience is critical to recovery from trauma
- Provides guidance and understanding of what helps overcome the negative effects of exposure to trauma and toxic stress
- Provides hope and both providers and recipients of care
- We can ‘break the cycle’



Concept of Resilience

Resilience is…	Resilience is not the same as…
Contextual and situational	Competence
Domain specific	Ego resiliency
Fluctuates over time	Grit
Person-environment perspective	Individual trait perspective

Person-environment perspective vs. Individual trait perspective

Adverse Childhood Experiences Study (ACES)

The Adverse Childhood Experiences (ACE) Study

The Center for Disease Control (CDC)- Kaiser Permanente (an HMO) adverse childhood experiences (ACE) study is one of the largest investigations of childhood abuse and neglect and household challenges on later-life health and well-being

- The original study was conducted at Kaiser Permanente from 1995 to 1997 with two waves of data collection
- Involved 17,000 people
- Looked at effects of adverse childhood experiences (trauma) over the lifespan
- Largest study ever done on this subject

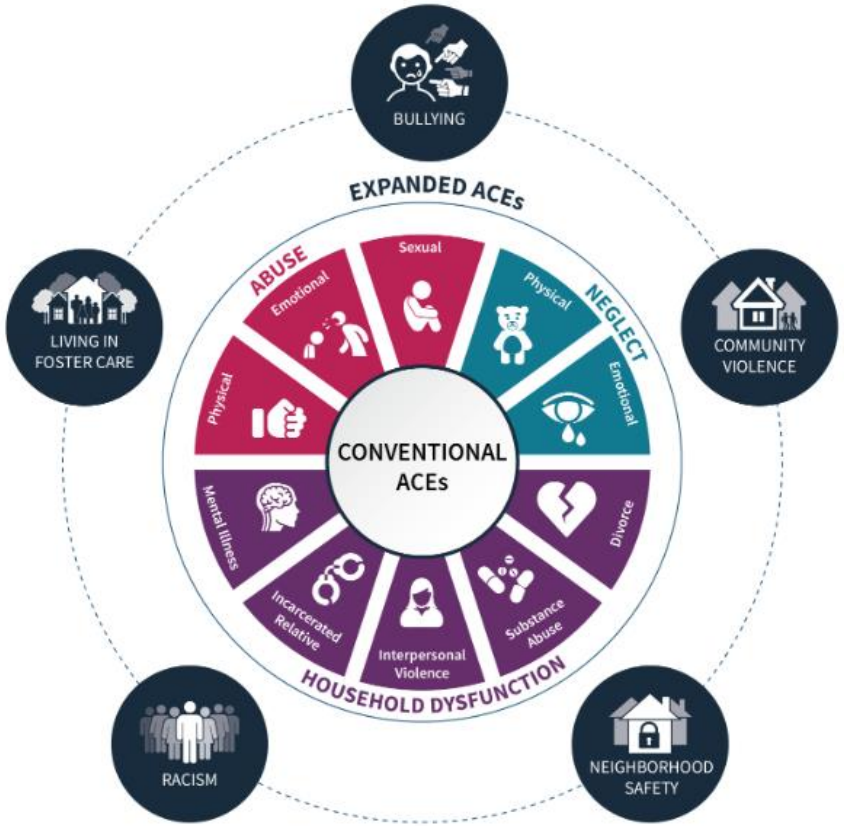
Prevalence of ACEs:

- 52% - 64% Exposed to at least 1 ACES
- 25% Exposed to 2 or more
- 16% Exposed to 4 or more

Expanded Adverse Childhood Experiences Study

The CDC and Kaiser Permanente (an HMO) study was an important first look at the impact of trauma but was done on a largely homogeneous group of people. All participants:

- Were medically insured
- Reported to be of middle to upper class status
- 69% reported to be white
- 74% of the participants reported having attended college.



Expanded Adverse Childhood Experiences Study

Efforts to Expand the Survey:
Subsequent studies like The Philadelphia ACE Project expanded that research to include ACEs among inner-city youth and the implications of intergenerational trauma.

(*Administration for Children and Families, Office on Trafficking in Persons*)

In this expanded study, 83.2% of participants had at least one ACE. From this survey the ACE list was expanded to include:

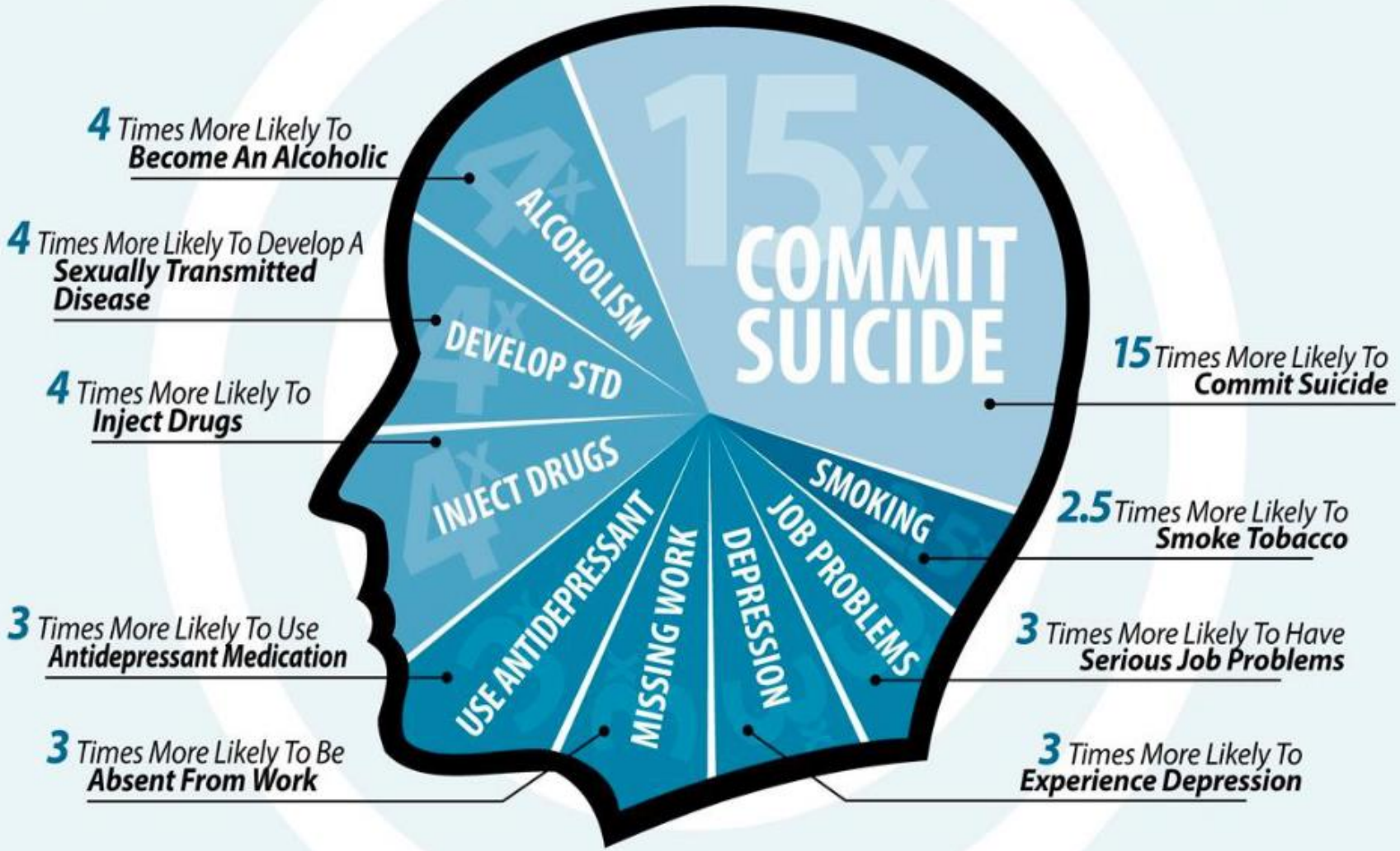
- Bullying
- Community violence
- Neighborhood safety
- Racism
- Living in foster care

List of ACEs

Emotional Abuse	Mother Treated Violently
Physical Abuse	Incarcerated Relative
Sexual Abuse	Physical Neglect
Substance Misuse	Emotional Neglect
Household Mental Illness	Parental Separation or Divorce

Main Study Finding: ACEs are common, and poor outcomes are more likely with more ACEs (dose response)

PEOPLE WHO HAVE EXPERIENCED TRAUMA ARE:



ACE's Relationships

Increasing ACE scores correlated with increasing risky health behaviors.

Trauma in Service Systems

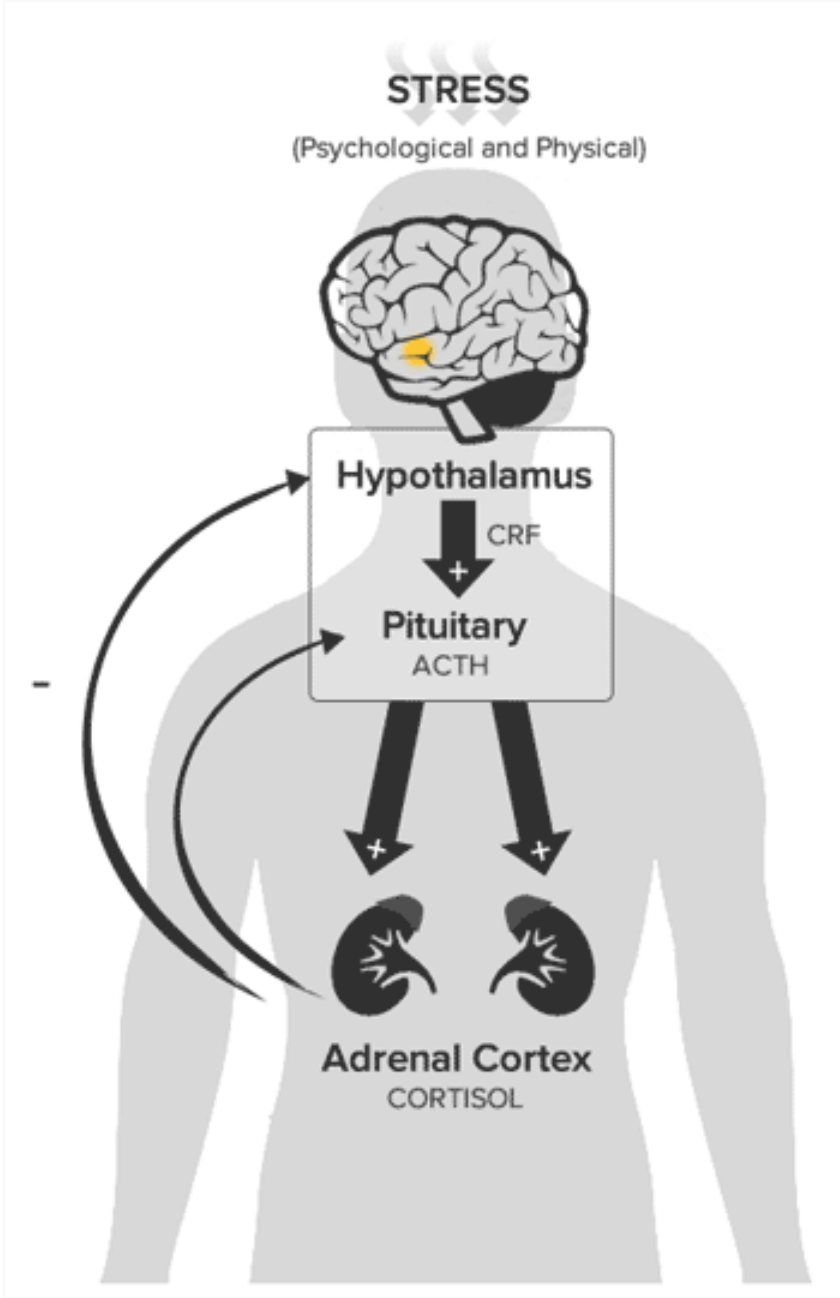
- 97% of homeless women with serious mental illness (a) experienced severe physical and sexual abuse (b) 87% experienced abuse in both childhood and adulthood
- 90% of public mental health participants have been (a) exposed to trauma, and (b) had multiple experiences of trauma
- In a US study of 100 adolescent psychiatric inpatients, 93% had histories of trauma and 32% had symptoms of PTSD
- A study of a State's child/adolescent long-term care service users (162) found 100% had documented histories of trauma
- 93% of males in a juvenile justice (JJ) facility reported trauma history (compared to 84% females), but more females met criteria for PTSD (18% female, 11% male)

Reference: Goodman, Mueser, Lipschitz, Massachusetts, Abram

Understanding the Human Stress Response

Chronic Stress

- Respiration increases
- Blood is forced away from digestion into our limbs
- Pupils dilate
- Awareness intensifies
- Sight sharpens
- Pain diminishes
- Immune system mobilizes with increased activation
- Focused on short-term survival

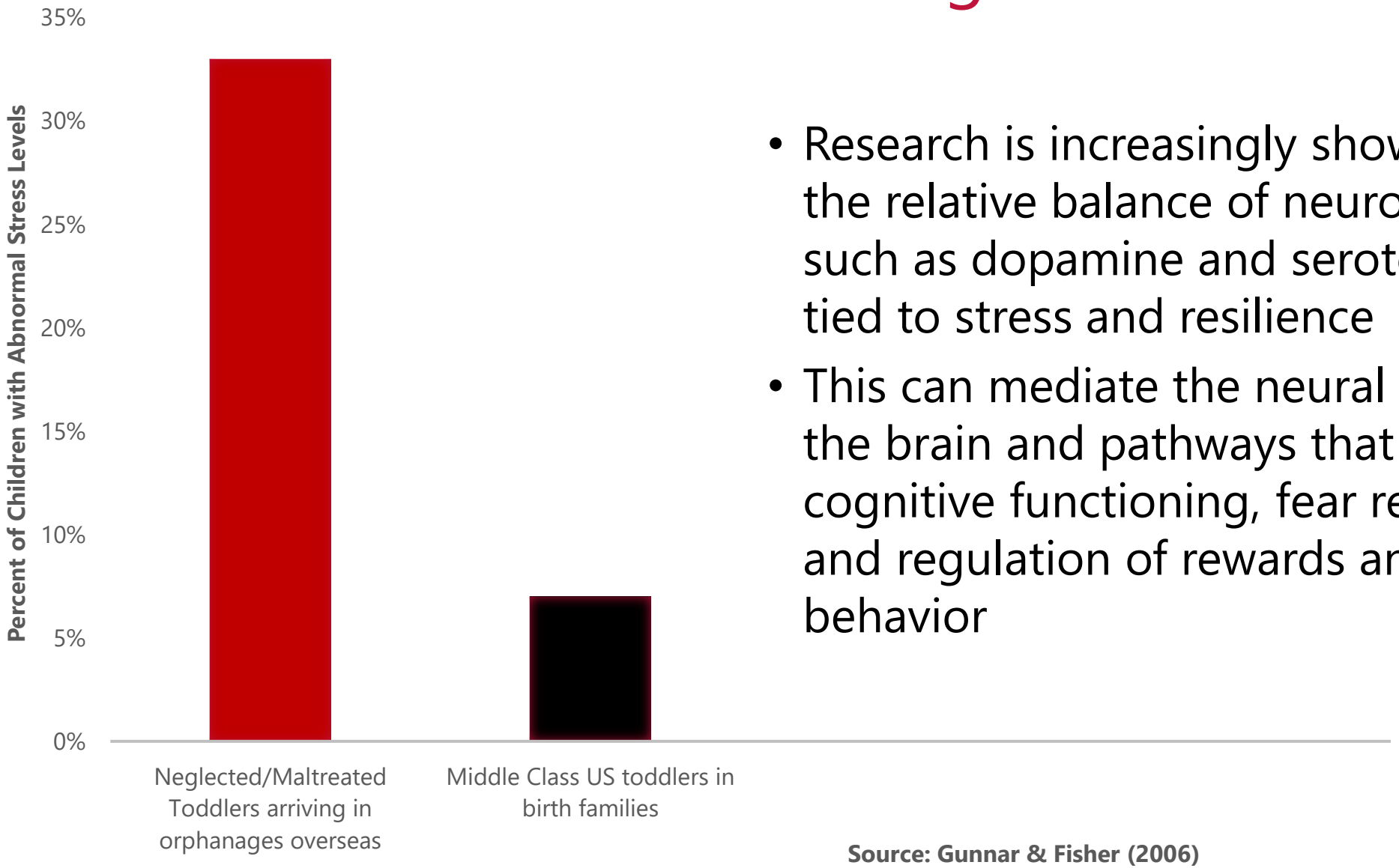


Chronic Stress

Exposure to chronic stress can over time overwhelm the human stress response and the immune system leading to physical health and mental health problems.

When the human stress response is overloaded, you can’t tell the difference between a real threat like a bear in the woods and something that is not a threat like the teddy bear.

Institutionalization & Neglect



- Research is increasingly showing that the relative balance of neurochemicals, such as dopamine and serotonin, are tied to stress and resilience
- This can mediate the neural circuits in the brain and pathways that impact cognitive functioning, fear response and regulation of rewards and social behavior

Source: Gunnar & Fisher (2006)

Normal Defensive Responses to High Threat

Trauma and Stress-Related Disorders and Different Types of Trauma

Post-Traumatic Stress Disorder (PTSD)

Exposure – direct or indirect	Intrusive symptoms	Avoidance	Negative alterations in cognition and mood	Alterations in arousal and reactivity
• Direct exposure • Witnessing the trauma • Learning that a relative or close friend was exposed to the trauma	• Sudden upsetting memories • Nightmares • Flashbacks • Emotional distress • Physical reactivity	• Thoughts or Feelings • People • Places • Events	• Incomplete memories • Trauma related emotions • Diminished interest • Withdrawal • Emotional numbing • Feelings of isolation	• Irritability or aggression • Risky or destructive behavior • Hypervigilance • Increased startle reaction • Difficulty concentrating • Sleep disturbances

Post-Traumatic Stress Disorder (PTSD)

Exposure – direct or indirect	Intrusive symptoms	Avoidance	Negative alterations in cognition and mood	Alterations in arousal and reactivity
• Direct exposure • Witnessing the trauma • Learning that a relative or close friend was exposed to the trauma	• Sudden upsetting memories • Nightmares • Flashbacks • Emotional distress • Physical reactivity	• Thoughts or Feelings • People • Places • Events	• Incomplete memories • Trauma related emotions • Diminished interest • Withdrawal • Emotional numbing • Feelings of isolation	• Irritability or aggression • Risky or destructive behavior • Hypervigilance • Increased startle reaction • Difficulty concentrating • Sleep disturbances

Trauma or Stress Related Disorders of Children

Disorder	Description
PTSD – Preschool Subtype	Recreating trauma in play; recurring dreams or nightmares; fear, guilt, sadness or withdrawing from friends/activities. Symptoms present for at least 1 month.
Disinhibited Social Engagement Disorder	Stemming from severe childhood neglect. Children exhibit overly familiar and comfortable behavior with relative strangers.
Reactive Attachment Disorder	Stemming from extremely insufficient care of a child. Infants and young children demonstrate disturbed or inappropriate attachment behaviors, are unable to get comfort, support, protection or nurturance from attachment figures.
Acute Stress Disorder	PTSD symptoms following a traumatic event that last from 2 days to 4 weeks after the event.
Adjustment Disorder	Emotional or behavioral symptoms in response to an identifiable stressor, including community violence, divorce, or termination of relationship.

Prevalence

Two-thirds of children experience at one ACES before 16: 30least.8% (1 event) 37% (2+ events)

- Most common events are vicarious - witnessing or learning about a trauma that affected others
- Approximately five million children experience some form of traumatic event each year
- More than two million children in the US are victims of physical and/or sexual abuse
- Childhood trauma most often results in depressive, disruptive behavior disorders and anxiety – not PTSD

Reference: Copeland

What is it?

- Depression
- Reactive Attachment Disorder
- Attachment Problems
- Substance Abuse
- Sexualized Behaviors
- ADHD
- Somatization
- Sleep Problems
- Phobias
- PTSD
- Dissociation
- Conduct Problems
- Enuresis
- Risk Taking
- Bipolar Disorder

Pain and Suffering

Moving from ‘What’s wrong with you?’ → ‘What happened to you?’ → ‘What’s most helpful for you?’

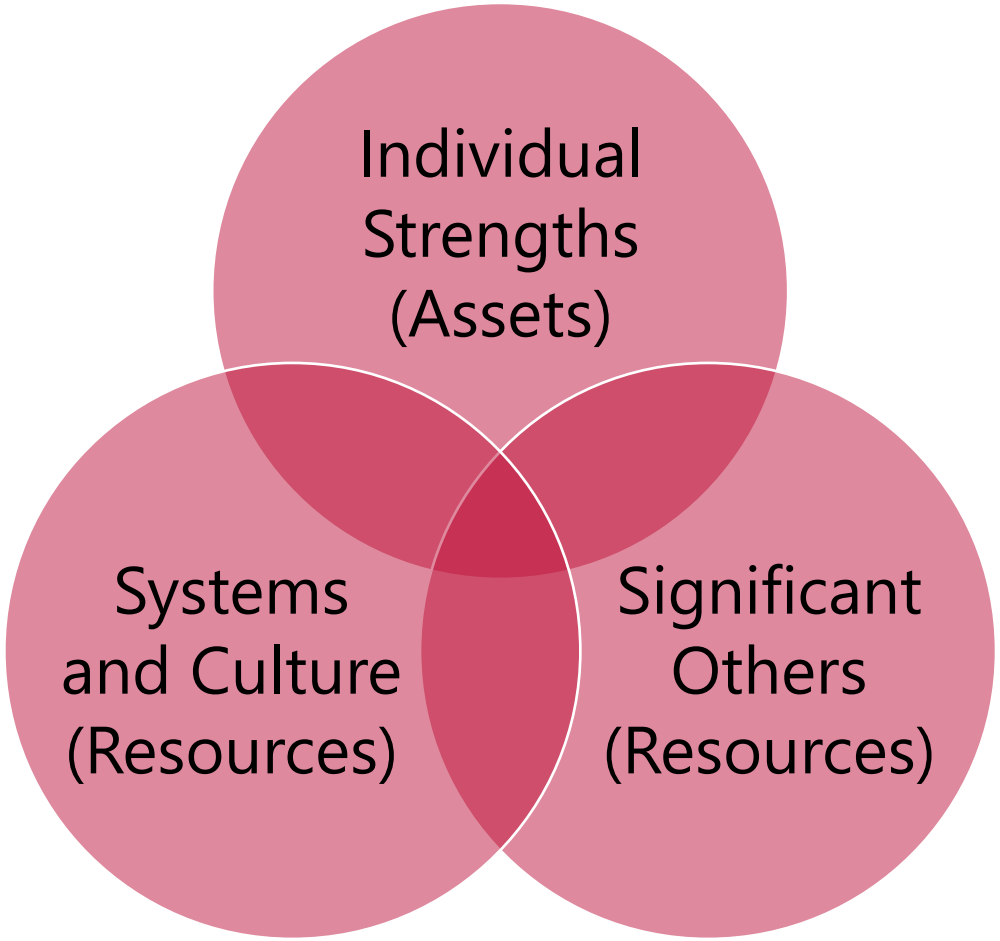
Various Forms of Trauma

- **Acute Trauma/Situational Trauma:** Results from exposure to a single overwhelming event → PTSD
- **Chronic or Toxic Stress:** Adverse experiences in childhood that threatens brain development and are associated with poor health and social problems → physical and behavioral health problems
- **Complex Trauma:** Exposure to multiple or prolonged traumatic events and impact of this exposure on development
- **Historical Trauma:** Refers to the *cumulative trauma* over both the life span and across *generations* that results from massive *catastrophic* events that are of human design

Understanding Resilience

Three Levels of Protection

Resilience informed care can best be understood as a dynamic process, residing at the intersection of individual characteristics, the importance of significant others and the availability of systems that care and a supportive culture. Individual strengths can include problem solving skills, self-control, the ability to control emotions, motivation, and social skills.

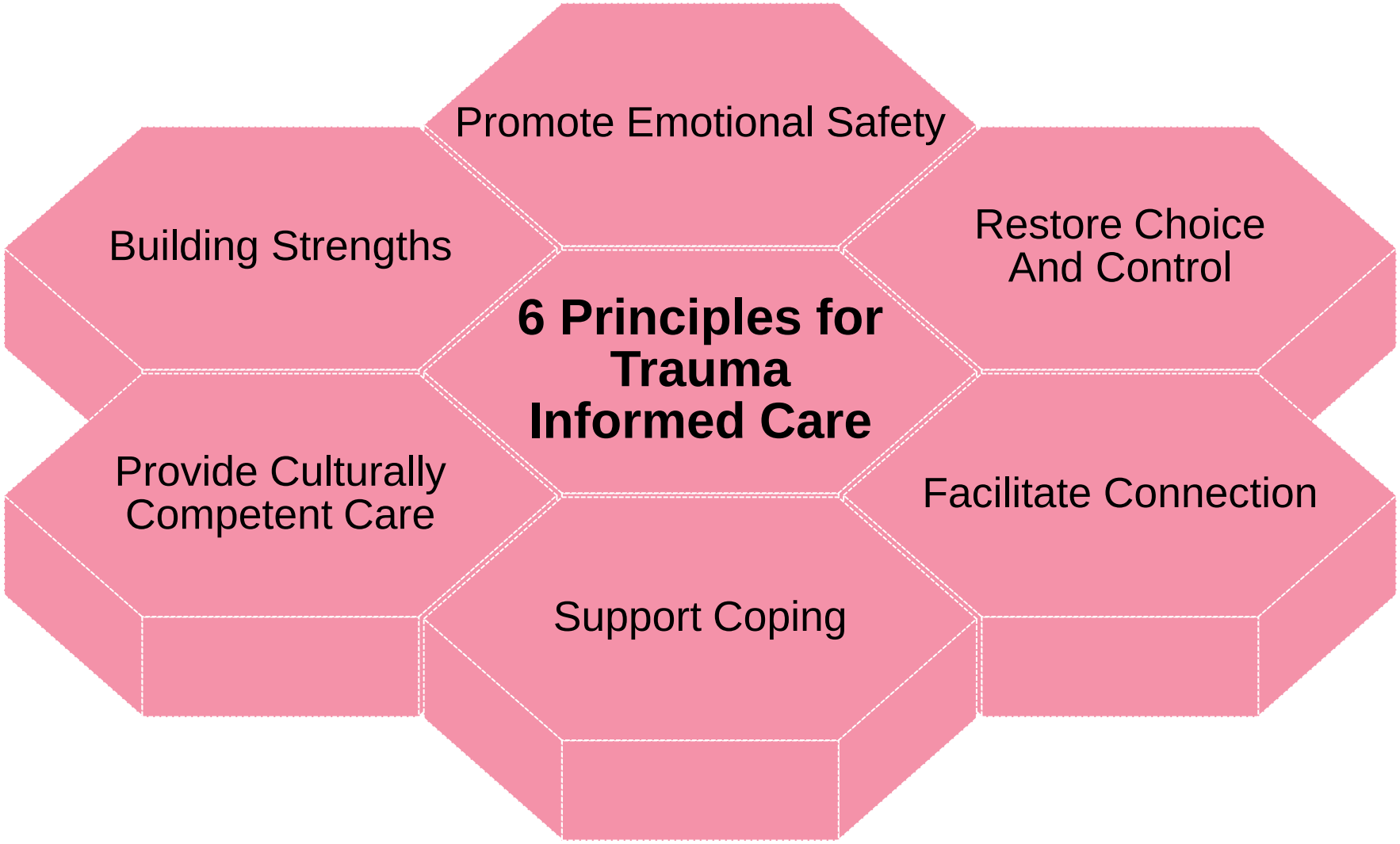


Ways of Building Resilience

- Build on strengths
  - Individual coping, emotional regulation, problem-solving
- Increase protective factors
  - Strengthening the family system – support parenting
  - Supporting the family system – economic supports, food security, healthy water and environment
  - Strengthening schools and services systems (e.g. child welfare, behavioral health, juvenile justice)
- Reduce exposure to risk
  - Prenatal care
  - Early intervention with parents and children

Tips: Trauma Informed Practices That Build Resilience

Principles



Promoting Emotional Safety

Promoting Safety

Goal/objective: adopt a non-judgmental approach about trauma in all communication with people

Rationale: People exposed to trauma and chronic stress are often self-critical, self-blaming

Emotional Safety:

- Accept people's responses
- Avoid embarrassing/shaming
- Give accepting messages

Emotional Safety:

- Calm tones
- Choice of words
- People first language (people with depression vs. "depressives"

Gentle/Non-Judgmental Questioning:

- Altering questions upon intake
- Open-ended question
- Querying commands
- Avoid interrogations/rapid-fire questioning
- Take frequent breaks

Promoting Safety

Goal/Objective: the program communicates policies clearly and safely

Rationale: exposure to trauma and adversity can affect learning and concentration and memory

- All staff can describe policies
- Connect policies to safety or control
- Repeat as often as is necessary
- Be transparent
  - What-to-expect discussions
  - Posting and changes in shifts

Restoring Choice and Control

Choice and Control: Objective 1

Goal/objective: provide opportunities for people to tell their stories

Rationale: healing from exposure to trauma and chronic stress starts with talking about it

- Provide appropriate space/time
- Provide choice of when to share*
- Pace conversations
- Offer non-threatening alternatives to talking
- Discuss safety
- Provide safety measures
  - Subjective units of distress (SUDS) Rating (e.g. how stressed on a scale of 1-10)
  - 'Happy' place (e.g. a place to go in imagination where the person feels safe

Choice and Control: Objective 2

Goal/objective: Provide opportunities for people to shape the focus of their work

Rationale: People exposed to trauma and adversity may feel little control over their own thoughts, feelings, and behaviors.

- Emphasize shared interactions
- Staff willing to learn from people
- Respect person expertise
- Ask for permission before offering unsolicited solutions
- Remember: people have learned
- Support state needs
- Offer services outside the box
- Start with small easy choices

Choice and Control: Objective 3

Goal/objective: people are given opportunities to influence how program services are designed and implemented

Rationale: shared decision making provides leadership opportunities and a greater sense of control

- Formal check-ins with individuals
- Organized listening sessions or town halls
- Anonymous surveys in the waiting area
- Program meetings for recipients
- Community Collaborative Boards

Facilitating Connection

Facilitating Connections: Objective 1

Goal/objective: invest in relationships with people – not necessarily intervention but how we relate
Rationale: people exposed to trauma and chronic stress may have difficulty trusting others or develop the sense that others don't care.

- Being fully present
- Accompany to other services
- 'Family' model – support
- Listen carefully
- Motivational Interviewing (open-ended questions, reflections, affirmations and summaries)

Facilitating Connections: Objective 2

Goal/objective: create opportunities for people to connect with each other → peer support

Rationale: people exposed to trauma and chronic stress may withdraw and isolate

- Create group opportunities
- Peer-led groups
- Recruit program participants

Facilitating Connections: Objective 3

Goal/objective: support parenting relationships

Rationale: Trauma can be intergenerational, and TIC is an opportunity to 'break the cycle'

- Psychoeducation on child trauma
- Psychoeducation on intergenerational/historical trauma
- Trauma treatment: Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)
- Promote positive parenting
- Use EBPs (PCIT, parent management training, MFG)
- Connecting parents with community resources

Supporting Coping

Support Coping: Objective 1

Goal/objective: promote coping that explicitly address the effects of the population you serve (e.g. child abuse, sexual abuse, DV)

Rationale: people exposed to trauma and chronic stress may develop unhealthy coping strategies

- Promote psychoeducation
  - Classes, videos, written materials
  - Topics: coercion, isolation
- Reframe all responses as adaptive
- Reframe request for breaks as self-care
- Address interactions of substance use/abuse and trauma

Support Coping: Objective 2

Goal/objective: support people in strengthening and developing coping strategies

Rationale: people exposed to trauma and chronic stress have strengths that can be built upon

- Strengthen coping skills
- Help participants recognize triggers
- Relaxation and breathing
- Containment skills
- Connecting with trusted others
- Message that 'healing is possible'
- Metaphors promote acceptance
- Church/template/synagogue
- Religiosity/spirituality
- Quotes/poems/affirmations
- Diet and healthy eating habits
- Exercise
- Smiling and positive thoughts
- Support holistic healing

Provider Culturally Competent Care

Providing Culturally Competent Care: Objective 1

Goal/objective: the physical space and services are inclusive and welcoming to people of all backgrounds

Rationale: people from marginalized groups often feel that services do not cater to them

- Written materials representative of peoples served
- Reading materials representative of people served
- Décor (e.g. posters, furnishings) representative of people served
- People can communicate in their language
- Avoid jargon, abbreviations and acronyms in communication
- Access to interpreters
- Staff reflect the diversity of the people served

Providing Culturally Competent Care: Objective 2

Goal/objective: affirm and respond to multiple identities Part 1

Rationale: research indicates that many practitioners feel unprepared to provide culturally competent care

- Staff explore own biases
  - Thoughts, feelings and behaviors
  - Avoid assumptions
    - Be mindful about matching
    - Cultural does not equal violence
- Staff acquire knowledge
  - Learn personal from individual
  - Learn of group on your own
  - Learn from the community
- Understand community differences

Providing Culturally Competent Care: Objective 3

Goal/objective: affirm and respond to multiple identities – Part 2

Rationale: research indicates that many practitioners feel unprepared to provide culturally competent care

- Awareness of multiple identities
- Awareness of intersectionality
- Differences in help-seeking
- Clarify meaning of violence within the cultural group
- Support engagement in cultural practices (dietary restrictions, religious practices)
- Information on cultural resources
- Engage community resources

Building Strengths

Building Strengths: Objective 1

Goal/objective: staff recognize and value strength

Rationale: people exposed to trauma and chronic stress have strengths that may not be recognized

Ask:

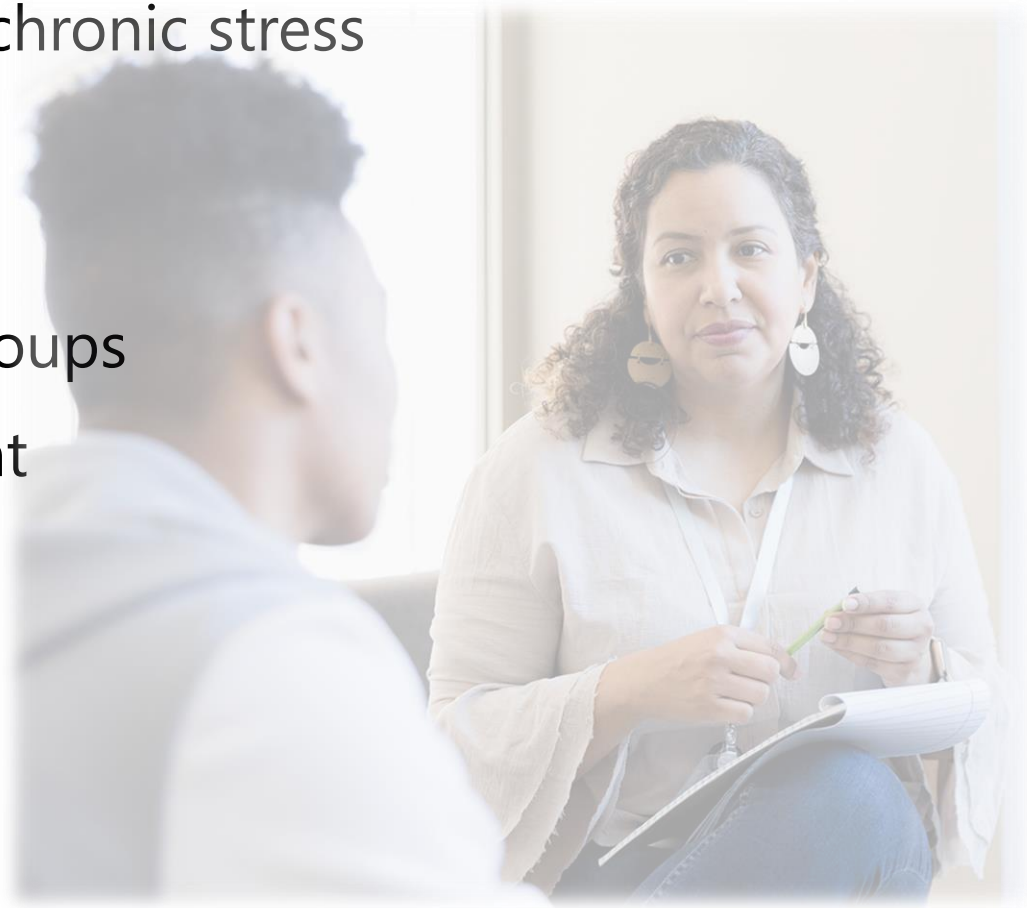
- What has helped in the past?
- How have you made it (this far)?
- How have you coped in the past?
- How have you managed emotions?
- Who do you feel safe with?
- How have you kept yourself safe?

Building Strengths: Objective 2

Goal/objective: provide opportunities for people to develop leadership skills

Rationale: people exposed to trauma and chronic stress may feel powerless

- Moving beyond survival and trauma
- Encourage people to select topics for groups
- Offer courses on leadership development



Resources

References

- SAMHSA, 2012
- Luthar & Zigler, 1991
- Garmezy, 1971
- Rutter, 1987
- Goodman et al, 1997
- Mueser et al, 1998
- Lipschitz et al, 1999
- Massachusetts DMH, 2007
- Abram et al, 2004
- Copeland et al., 2007

Resources

Get Started with Trauma-Informed Care - Trauma-Informed Care Implementation Resource Center (chcs.org)

Treating Trauma Master Series - 5 Part Series on the Treatment of Trauma (nicabm.com)

Trauma-informed Care - PTSD: National Center for PTSD (va.gov)

Trauma-Informed Care | The National Child Traumatic Stress Network (nctsn.org)

Practical Guide for Implementing a Trauma-Informed Approach | SAMHSA

Thank you for being part of MVP

Contact your Behavioral Health Professional Relations Representative with questions. Visit the MVP Website to identify your representative and contact information by county.

Contact: Professional Relations Territory Listing Behavioral Health (mvphealthcare.com)