Overview of Trauma Informed Care and Historical Trauma Informed Care

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Introduction

- IHS has partnered with the University of New Mexico School of Medicine Division of Community Behavioral Health to
- Present an integrated approach to Historical Trauma, Trauma, and Trauma Informed Care in health and behavioral health settings
- Rollout of:
  - A series of webinars
  - Monthly learning collaboratives or case consultations
- Today's webinar is an overview
- There will be follow up in depth webinars tailored to the needs of different groups
  - Healthcare providers, behavioral health care providers, non clinicians, administrators

Objectives

1. Integrate five core values of Trauma Informed Care into systems of care.

2. Formulate examples of historic trauma in Indian Country and how they are transmitted from generation to generation;

3. Evaluate similarities and differences in historical, complex and vicarious trauma.

4. Assess the consequences of trauma on physical and behavioral health.

Polling Question 1

- What is your primary professional affiliation?

1. MD/DO, Nurse practitioner, Physicians Assistant
2. Nurse
3. Medical assistant
4. Psychiatrist
5. Psychologist
6. Social worker (LCSW, LISW)
7. Other therapist (LPCC, etc.)
8. Supervisor/administrator
9. Front Desk Staff
10. Community health representative
11. Peer support worker

Trauma Informed Paradigm

"What happened to this person?"

"What's strong with you?"

Historical trauma informed:

"What tribal traumatic events happened over time?"

"What kind of school did you and family members attend?"

Standard Paradigm

"What's wrong with this person?"
"What's wrong with you?"

NOT asking about collective tribal history

NOT asking about boarding school history or other tribal-specific experiences and culture

Historical Trauma: Implications for Trauma Informed Care and Healing

Tunkasila Tatanka Iyotake, Mother Her Holy Door,
Daughter, and Grandchild

Polling Question 2

- How knowledgeable are you about Historical Trauma Informed Care?

1. Not at all

2. A little

3. A fair amount

4. A lot

Introduction

It is our way to mourn for one year when one of our relations enters the Spirit World. Tradition is to wear black while mourning our lost one, tradition is not to be happy, not to sing and dance and enjoy life's beauty during mourning time. Tradition is to suffer with the remembering of our lost one, and to give away much of what we own and to cut our hair short....Chief Sitting Bull was more than a relation....He represented an entire people: our freedom, our way of life -- all that we were. And for one hundred years we as a people have mourned our great leader.

Introduction-continued

We have followed tradition in our mourning. We have not been happy, have not enjoyed life's beauty, have not danced or sung as a proud nation. We have suffered remembering our great Chief and have given away much of what was ours…. blackness has been around us for a hundred years. During this time the heartbeat of our people has been weak, and our life style has deteriorated to a devastating degree. Our people now suffer from the highest rates of unemployment, poverty, alcoholism, and suicide in the country.

Traditional Hunkpapa Lakota Elders Council (Blackcloud, 1990)

Intergenerational Parental Trauma

I never bonded with any parental figures in my home. At seven years old, I could be gone for days at a time and no one would look for me....I've never been to a boarding school....all of the abuse we've talked about happened in my home. If it had happened by strangers, it wouldn't have been so bad- the sexual abuse, the neglect. Then, I could blame it all on another race....And, yes, they [my parents] went to boarding school.

A Lakota Parent in Recovery

(Brave Heart, 2000, pp. 254-255)

Multiple Losses, Trauma Exposure, & Psychosocial Risk Factors

- Death of five family members killed in a collision by a drunk driver on a reservation road

- One month earlier, death of a diabetic relative

- Following month, adolescent cousin's suicide and the death of another relative from a heart attack

- Surviving family members include individuals who are descendants of massacre survivors & abuse in boarding schools

- Many community members comment that they feel they are always in a state of mourning and constantly attending funerals.

- We have high rates of PTSD due to the degree of trauma exposure in tribal communities

Historical Trauma and Unresolved Grief

- ***Historical trauma*** (HT)- Cumulative emotional and psychological wounding from massive group trauma across generations, including lifespan

- ***Historical trauma response*** (HTR) is a constellation of features in reaction to massive group trauma, includes ***historical unresolved grief*** (similar to Child of Survivors Complex re: Jewish Holocaust survivors and descendants, Japanese American internment camp survivors and descendants), depression, PTSD

  (Brave Heart, 1998, 1999, 2000)

Historical Trauma, Genocide and Survival:
the Elephant in the Room

- **Congressional genocidal policy:** *no further recognition of their rights to the land over which they roam….go upon said reservations…chose between this policy of the government and* **extermination**….*wards of the government, controlled and managed at its discretion* (U.S. Senate Miscellaneous Document 1868 cited in Brave Heart, 1998)

- **BIA** started under the **War Department**; BIA **Education Division called "Civilization Division" & IHS evolved from BIA**

- **Congressional policy of forced separation** **of children from family and tribe – early boarding school trauma**

- **Honesty about this legacy and impact upon current relationships, mistrust, and strategies to move forward are part of trauma informed care**

Ways HT May Be Transferred

- Identification with and internalization of oppressor's view, resulting in self-hatred, self-destructiveness

- Identifying with parents' trauma responses; other mechanisms of transfer across generations (epigenetic research may provide further insight)

- Past prohibition against practice of traditional burials limited bereavement, complicating grief resolution

- Active relationships with ancestor spirits and cultural attachment styles include death as a loss of part of self (e.g. exhibited by cutting the hair); without traditional culturally congruent mourning practices, grief could become impaired

Testimonies of HT

I think losing the land was the most traumatic....I remember my... dad talked about...how they were treated, some were shot...They were starved....So this happened in my great grandparents' generation when they lost the buffalo. My grandparents' generation lost the land and their livelihood....That's from generation to generation. There are a lot of answers that I don't have and a lot of questions that I do have and there is a lot of hurt inside me....Some of these things happening over the years are still happening today, like my grandparents, my great grandparents had their children moved to schools....I was moved, my brothers and sisters moved....There's a big hole in my heart. We see it happening to our grandchildren already....Where does it stop? (Brave Heart, et al., 2012)

Prevalence of Historical Trauma

One-fifth to one-third of Indigenous adults reported thoughts pertaining to historical loss daily or several times a day, and that these thoughts have negative emotional consequences (Whitbeck et al., 2004).

●

Some Historical Trauma Response Features

- ***Survivor guilt***

- ***Depression***

- ***PTSD* symptoms**

- ***Psychic numbing***

- ***Fixation to trauma***

- **Somatic (physical) symptoms**

- **Self-destructive behavior including substance abuse**

- **Suicidal ideation**

- ***Traditional cultural attachment***

- Death identity – fantasies of reunification with the deceased; cheated death

- Preoccupation with trauma, with death

- ***Loyalty to ancestral suffering & the deceased***

- **Internalization of ancestral suffering**

- ***Vitality in own life seen as a betrayal to ancestors who suffered so much***

Case Examples

- 15 year old American Indian girl with recovering boarding school survivor parents attempts suicide – after a few therapy sessions, the girl reveals that she didn't want to burden her parents with her problems because they have suffered so much from their boarding school trauma.

- 43 year old recovering alcoholic, with history of physical abuse and neglect by alcoholic boarding school survivor parents, experiencing suicidal impulses, depressed and unable to cry; placed on anti-depressants and in mainstream psychotherapy but symptoms are not alleviated

Case Examples

- 11 yr old male sexually abused in boarding school acting out, drinking. Mother and grandmother were boarding school survivors. Grandmother raising child due to the mother's alcoholism and neglect; youth feeling hopeless and saw no future for himself. Grandmother overwhelmed as she was raised in boarding school and felt she did not know how to raise grandson.

- Sexual abuse survivor (family history of abusive boarding school experience) finding a new family through traditional adoption – ostracized by own family for disclosing abuse; using tribal tradition to support self and have a new reparative family experience.

Celebration of Survival

Video Presentation:

A Celebration of Survival: The Takini Network (supported by CSAT)

- includes historic boarding school slides

- summarizes historical trauma intervention theory and approach

- describes historic 2001 _Models for Healing Indigenous Survivors Conference_

Follow up conferences held in 2003 and 2004 (CMHS and CSAT funded)

Types of trauma

Polling Question 3

- How many of the patients/clients you work with/are seen at your service unit have experienced trauma?

- 0-10%

- 11-25%

- 26-50%

- 51-75%

- Over 75%

Realizing the Widespread Effects of Trauma

- Over 60% of adults report at least one adverse childhood experience (ACE)

- Up to 68% of youth in the US have experienced at least one traumatic event during childhood

- 70% of adolescents receiving substance abuse treatment have a history of trauma exposure

- Men with PTSD are 5 times more likely to abuse substances; women are 1.4 times as likely
  - The most common traumas associated with substance use disorders involve sexual, physical, and emotional abuse.

Trauma Exposure in American Indian Men

- American Indian males have non-interpersonal trauma exposure rates of 25.2% in SW and 36.4% in NP, including natural disasters, life-threatening accidents (Manson, et al., 2005)

- Interpersonal trauma exposure rates (assault, rape, abuse, combat) – 25.5% in SW and 31% in NP for Native men

- Witness to trauma – 46.7% SW & 46.3% NP

- **Many Native military and veterans may be *wakiksuyapi,* carrying both historical trauma and modern combat trauma**

Impact of Trauma on American Indian and Alaska Native Communities

- AI/AN between 2-3 times more likely to meet PTSD criteria compared to US adult population

- 2.5 times greater risk than the national average of experiencing physical, emotional, and/or sexual abuse

- AI/AN youth have the highest rates of emotional or physical neglect across all populations

- Up to 74% of AI/AN youth have experienced at least one traumatic event during childhood

- 12-16% of AI/AN homes experience alcohol and/or drug abuse (national average is 4-6%)

- Unresolved grief and historical trauma can become ingrained in the identity of individuals and communities

What Is Trauma?

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

Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801.

Types of Trauma

- Single event
  - E.g. being in a car crash, natural disaster, sexual assault

- Multiple events, over time
  - E.g. incest, war, racism, micro-aggressions
  - Can lead to Complex Trauma

- Vicarious or secondary trauma

- Multigenerational including historical trauma

Caveats

- What is traumatic to 1 person may not be to another
- Trauma affects a person's neurobiology in ways that are long lasting or permanent
- Trauma can lead to
  - adverse physical and mental health outcomes
  - PTSD
- Not everyone who has experienced trauma develops PTSD or adverse health outcomes
- Cumulative trauma has cumulative effects
- There are effective treatments for trauma

Culture and Trauma

Culture determines acceptable responses to trauma and shapes the expression of distress

• Culture affects what qualifies as a legitimate health concern and which symptoms warrant help

Culture can provide a source of strength, unique coping strategies, and specific resources.

Cultural assessment is essential for appropriate diagnosis and care

Vicarious or Secondary Trauma

- Experienced by healthcare providers
  - Patients ill and dying
  - Hearing stories of medical trauma
  - Experiencing historical trauma themselves
  - Experiencing trauma themselves
- Experienced by behavioral health providers
  - Hearing stories of trauma from their clients
  - Experiencing historical trauma themselves
  - Experiencing trauma themselves

The System(s) We Work in Can be Traumatizing/Re-traumatizing for Us

- We are all affected by systemic stressors

- We are trained to ignore our own emotions, thoughts, and needs

- We are trained to focus on the patient and their needs

- Many of us have experienced our own trauma in ourselves, our families, our communities

- This can lead to compassion fatigue and burn out

Compassion Fatigue

- The emotional residue or strain of exposure to working with those suffering from the consequences of traumatic events.

- It differs from burn-out, but can co-exist.

- Can occur due to exposure on one case or can be due to a "cumulative" level of trauma.

Signs and Symptoms of Compassion Fatigue

- Exhaustion

- Reduced ability to feel sympathy and empathy

- Anger and irritability

- Increased use of alcohol and drugs

- Dread of working with certain clients/patients

- Diminished sense of enjoyment of career

- Disruption to world view, Heightened anxiety or irrational fears

- Intrusive imagery or dissociation

- Hypersensitivity or Insensitivity to emotional material

- Difficulty separating work life from personal life

- Absenteeism – missing work, taking many sick days

- Impaired ability to make decisions and care for clients/patients

- Problems with intimacy and in personal relationships

Burn Out

- "A syndrome of emotional exhaustion, depersonalization and lack of feelings of personal accomplishment" (Lee & Ashforth)

- Cumulative process marked by emotional exhaustion and withdrawal associated with increased workload and institutional stress, <u>NOT</u> trauma-related. (American Institute of Stress)

- A concept in organizational psychology—occurs when a person's work environment is so toxic or stressful they don't see value in their work

Protective Factors to Prevent Compassion Fatigue & Burnout

- Team spirit/cohesion

- Sense of accomplishment

- Training

- Supervision

- Balance in life outside of work

- Connection to others

- Self-care

The Ethics of Self-Care:
Standards of self-care guidelines:

• Respect for the dignity and worth of self: A violation lowers your integrity and trust.

 • Responsibility of self-care: Ultimately it is your responsibility to take care of yourself—and no situation or person can justify neglecting this duty.

• Self-care and duty to perform: the duty to perform as a helper cannot be fulfilled if there is not, at the same time, a duty to self-care

Self-Care

- Create daily schedule with breaks for rest, exercise, connection with coworkers, other self-care activities

- Support staff in recognizing their value and need to nurture themselves, increasing commitment to self-care.

- **Connection** to self, to others, and to something greater than the self. Connection decreases isolation, increases hope, diffuses stress, and helps counselors share the burden of responsibility for client care.

- *Utilize traditional Native symbols and practices for calming, soothing, uplifting, "emotional containers" such as smudging, songs, prayers, healing and strengthening symbols, spaces, etc. [added re: Native perspectives]*

Stress

Three Levels of Stress Response

Positive
Brief increases in heart rate,
mild elevations in stress hormone levels.

Tolerable
Serious, temporary stress responses,
buffered by supportive relationships.

Toxic
Prolonged activation of stress response systems
in the absence of protective relationships.

Acute Stress

- Our bodies are designed to deal with acute stress
- Fight/flight/freeze reaction is initiated
- This stress response system increases our ability to survive danger
- Once stress is over systems return to normal (homeostasis) via negative feedback loops

Chronic Stress

- Chronic stress
  - Our bodies are not designed to deal with stress that doesn't go away
  - Same systems are activated as in acute stress, but are activated over and over
  - This has adverse effects
    - Initial high levels of cortisol then blunted corticosteroid release
    - Brain changes (high levels of cortisol are toxic)
      - Impairs neural plasticity, damages the hippocampus which impairs memory
    - Epigenetic changes
  - These adverse effects lead to increased risk of physical and psychiatric illness

Epigenetics and Stress/Trauma

- Gene expression is influenced by experience/environment

- Stress and trauma affect gene expression

- Epigenetics shows how stress/trauma can affect biological systems on a molecular level, leading to disease

- Historical trauma can affect subsequent generations via epigenetics

- Epigenetic changes can be reversed

Epigenetics, Transgenerational Effects, and PTSD

- Transgenerational, higher stress vulnerability (doesn't mean poor mental health necessarily but greater *risk* for traumatic responses to stress and more likely to have PTSD-like symptoms)

- Stressful environmental conditions *can* leave a genetic imprint, changes in neurobiology

- Testimonies of "inherited" grief in qualitative research

Adverse childhood experiences (ACES)

ACE (Adverse Childhood Experience) Study

- Looked at the relationship between childhood abuse and neglect and later-life health and well-being

- Original ACE study done from 1995-1997 at Kaiser Permanente in S California in collaboration with US CDC

- Surveyed 17,000+ HMO members who completed a confidential survey given to them when they came for their physical exam
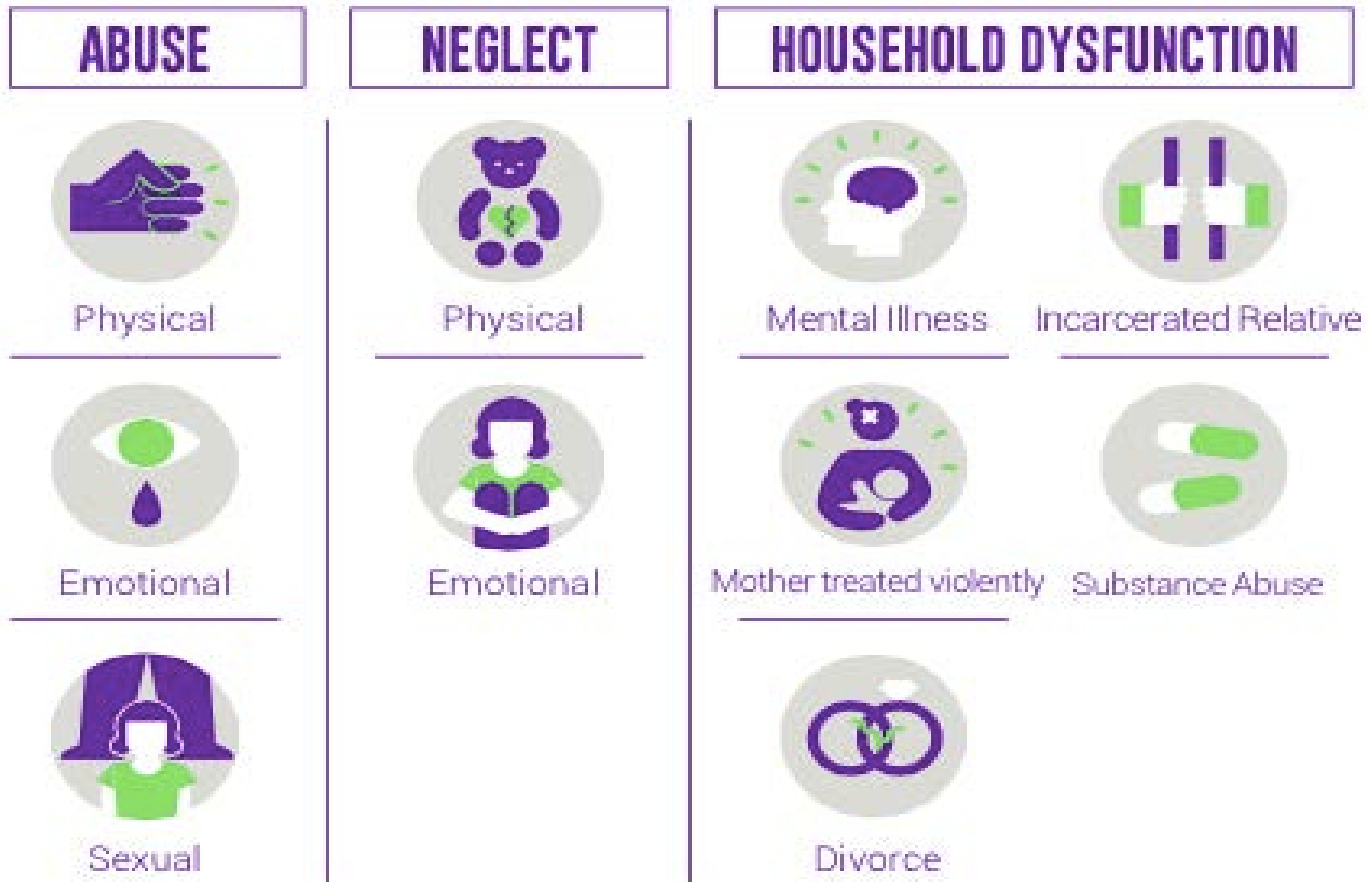
  - 70% Caucasian
  - 70% college educated

The three types of ACEs include

ABUSE	NEGLECT	HOUSEHOLD DYSFUNCTION	
Physical	Physical	Mental Illness	Incarcerated Relative
Emotional	Emotional	Mother treated violently	Substance Abuse
Sexual		Divorce	

FIGURE 1: Types of Adverse Childhood Experiences
Image courtesy of the Robert Wood Johnson Foundation

How Common are ACES?

ACE Study

ZERO
36%

ONE
26%

TWO
16%

THREE
9.5%

FOUR OR MORE
12.5%
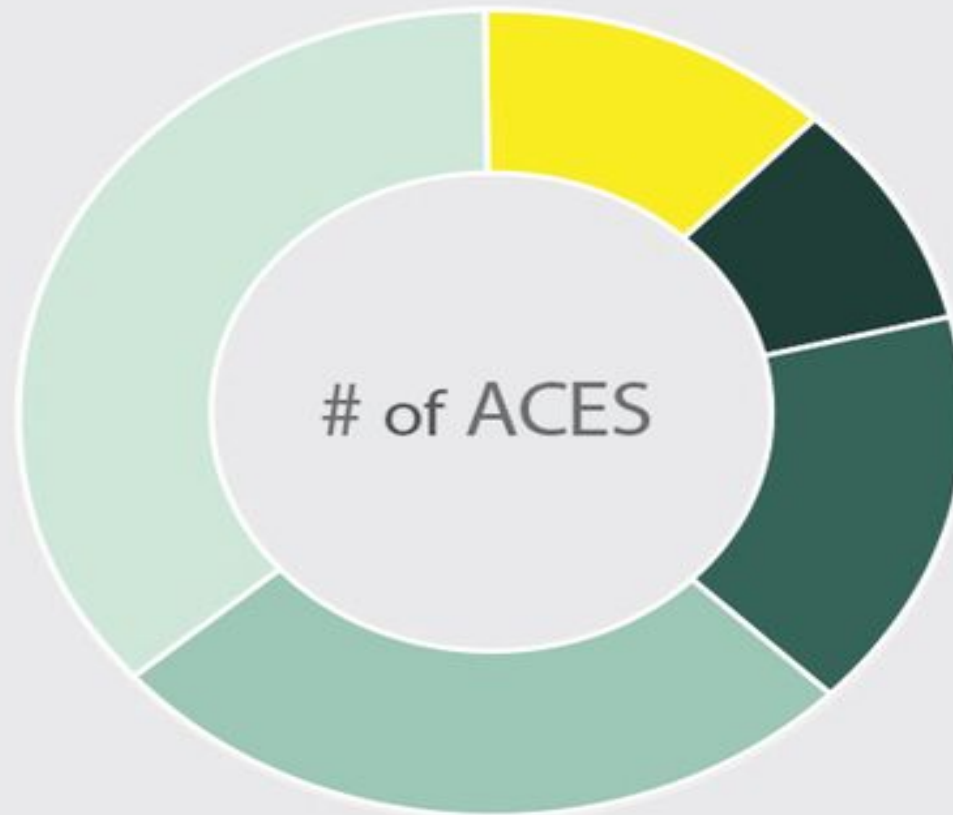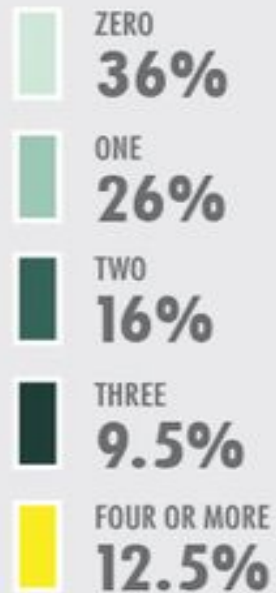
# of ACES

Major Findings

- 64% reported at least one ACE

- 1in 8 people had 4+ ACEs

- Relative risk for multiple physical, mental health and psychosocial outcomes increased with number of ACEs

- Risk increases even if people don't engage in high risk behaviors such as smoking, drug or alcohol use

BEHAVIOR

Lack of physical activity	Smoking	Alcoholism	Drug use	Missed work

PHYSICAL & MENTAL HEALTH

Severe obesity	Diabetes	Depression	Suicide attempts	STDs
Heart disease	Cancer	Stroke	COPD	Broken bones
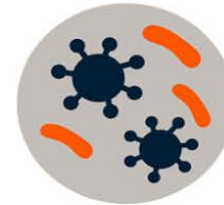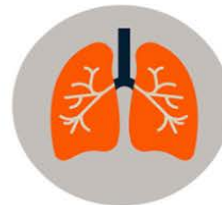
Odds of Heart Disease With Increasing Aces

Death

Conception

Early Death

Disease, Disability, and Social Problems

Adoption of Health-risk Behaviors

Social, Emotional, and Cognitive Impairment

Disrupted Neurodevelopment

Adverse Childhood Experiences
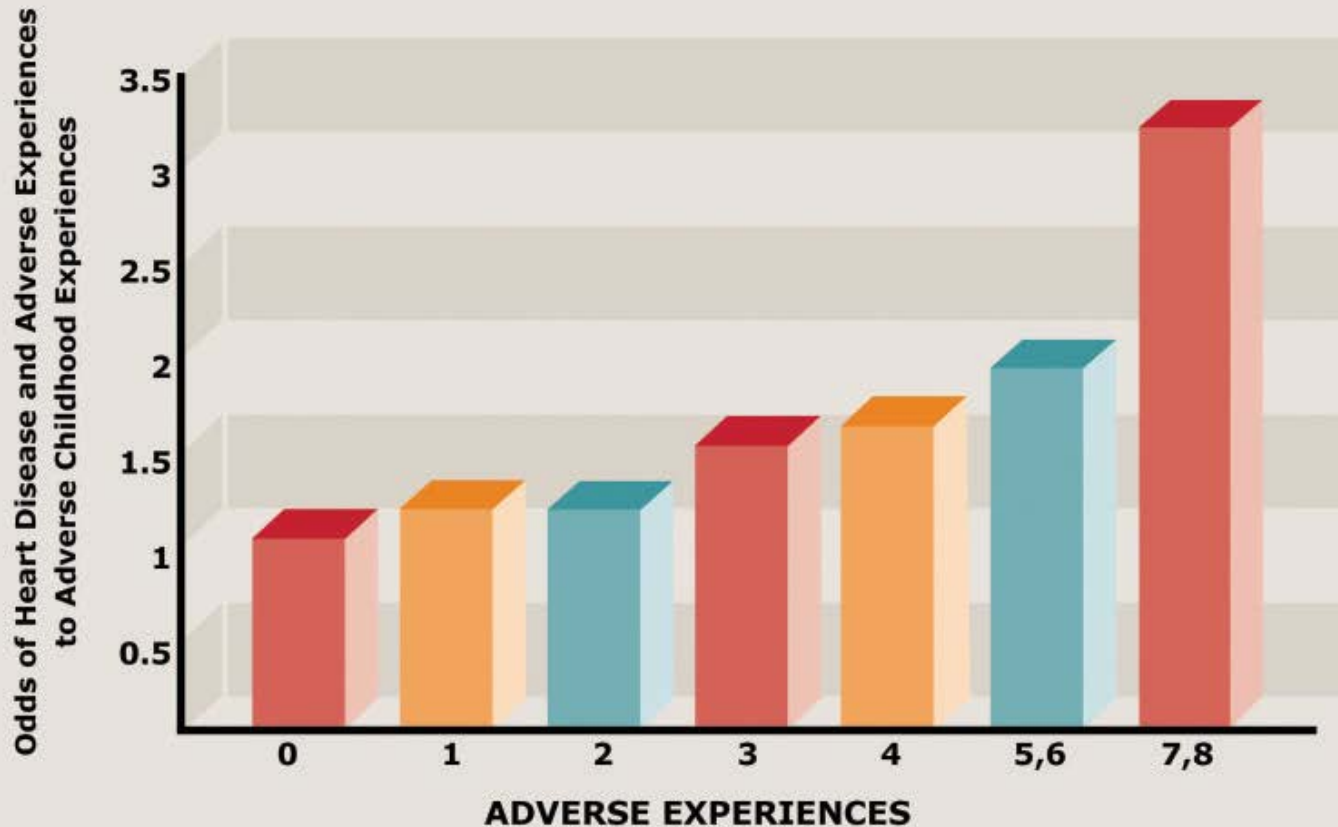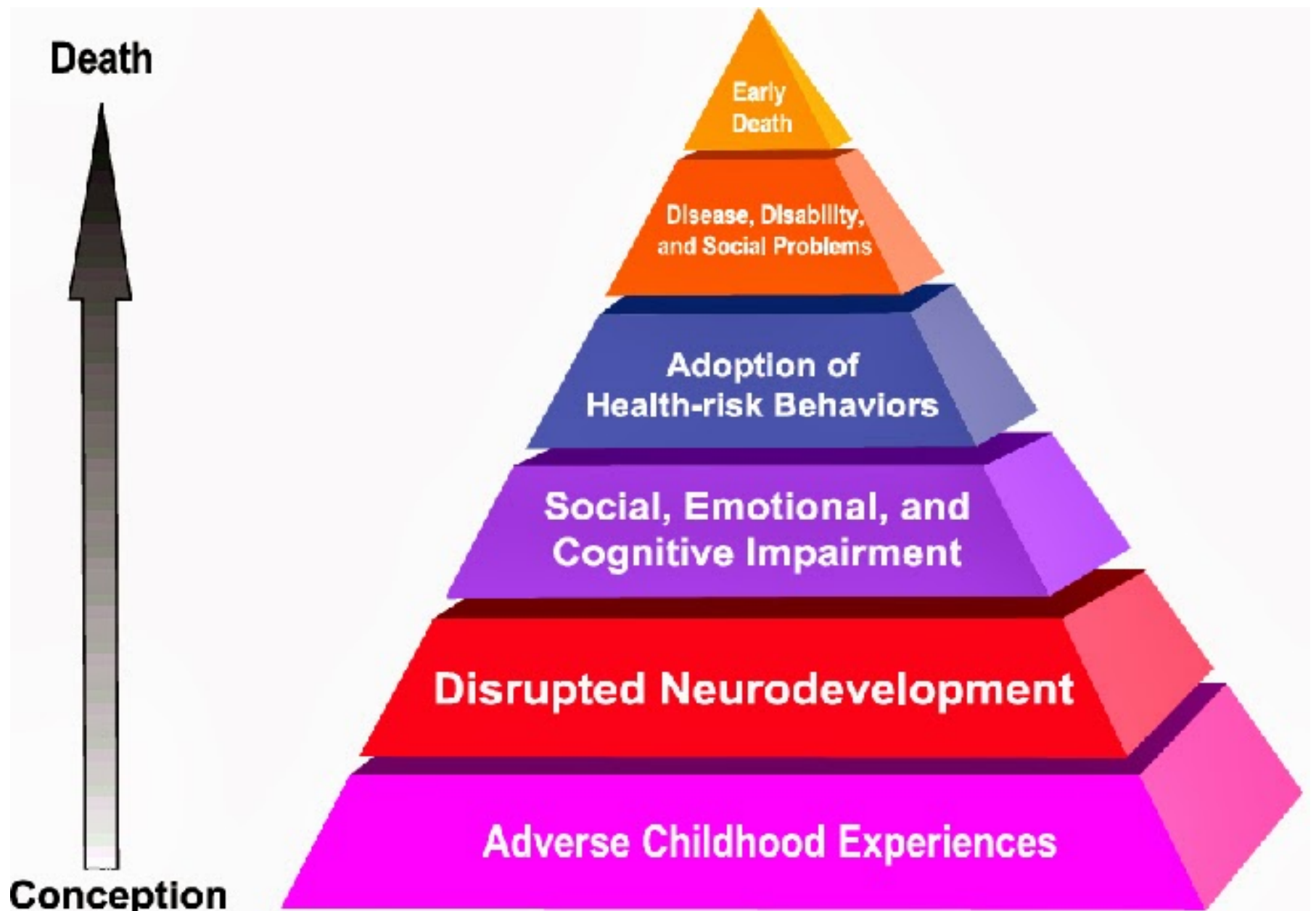
Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Health Disparities in AI/AN

- AI/AN have lower life expectancy

- Reservation-based AI/AN have higher rates of death from:
  - Tuberculosis 750% higher
  - Alcoholism 524% higher
  - Diabetes 293% higher
  - Unintentional injuries 153% higher
  - Homicide 103.3% higher
  - Suicide 66% higher

Brockie et al., 2013

ACE Scores Among AI/AN children compared with non Hispanic white children

AI/AN

- 2+ACEs 40.3%
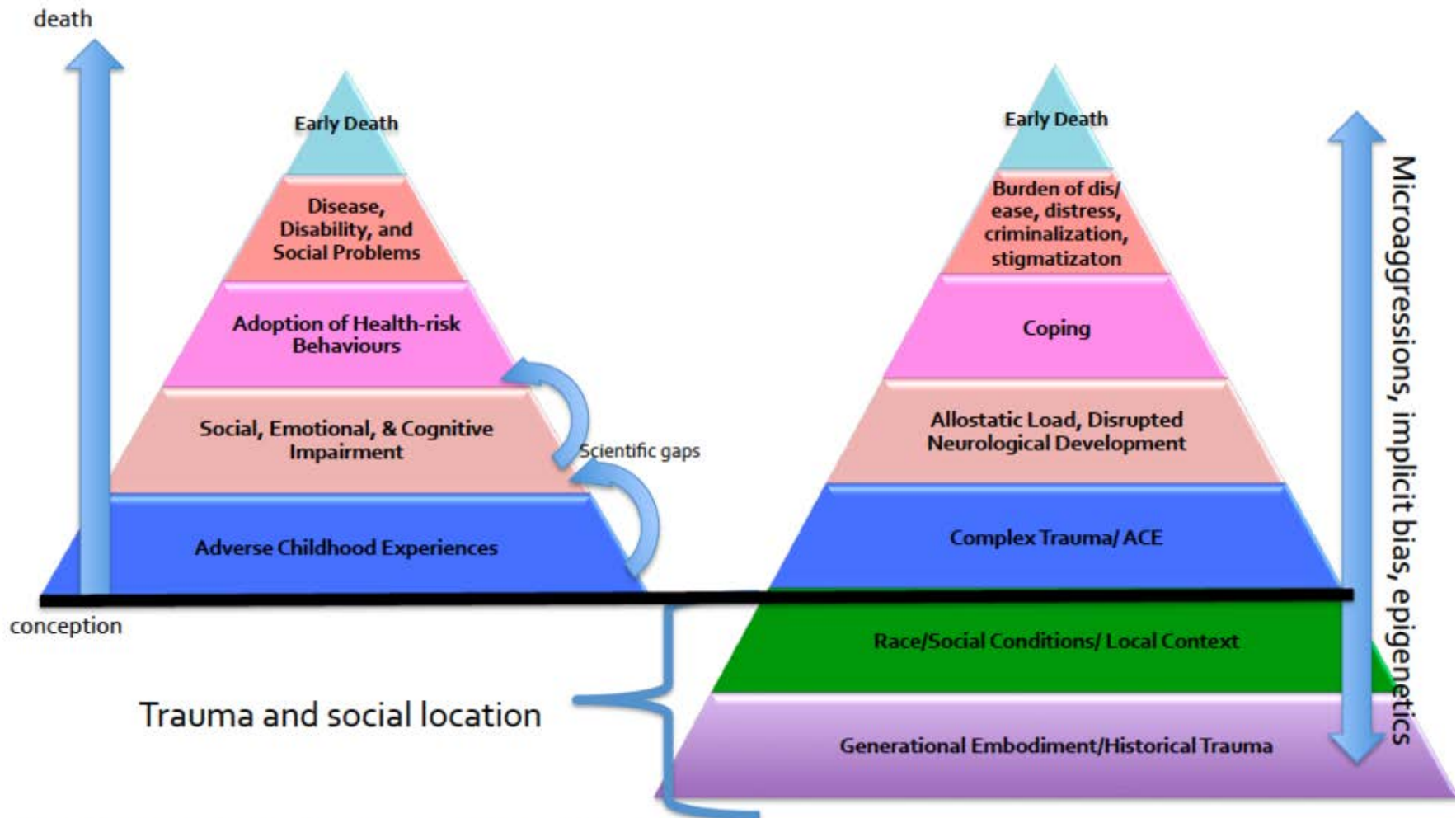
- 3+ ACEs 26.8%

- 4+ ACEs 16.8%

- 5+ ACEs 9.9%

Once adjusted for sociodemographic variables, the differences between the 2 populations went away

NHW

- 21%

- 11.5%

- 6.2%

- 3.3%

Trauma and Social Location

Effects of Childhood Abuse on Healthcare Behaviors

- Avoidance of care
  - Decreased access of pap smears and mammography (childhood sexual abuse)
  - Delay in seeking treatment
  - Decreased adherence to treatment
  - **Avoidance can be related to fear and complex identification issues, behavioral health issues, with family members who have or died from an illness**
- Overutilization of care
- Trauma reactions while receiving medical care

PTSD, and complex trauma

Posttraumatic Stress Disorder

- Involves exposure to "actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways"
  - Direct experience
  - Witnessing the event occur to others
  - Learning that the event occurred to a family member or friend
  - Experiencing "repeated or extreme" exposure to details of the traumatic events (can include occupational exposure e.g., first responders)

PTSD Diagnostic Criteria-continued

- Presence of symptoms in different domains:
    - intrusion
    - avoidance
    - negative cognition or mood
    - change in arousal and reactivity
    - Lasts for more than 1 month
- Onset usually within 3 months after trauma but can be delayed

Prevalence of PTSD in USA

- Lifetime risk for development of PTSD by age 75 is 8.7%

- Lower rates among children

- Lower rates among elderly

- Higher rates among veterans, occupational exposure

- Certain ethnicities have higher rates compared to non Hispanic white: AI/AN, Latinos, African Americans

- Lower rates among Asian Americans

- Survivors of rape, military combat and captivity, ethnically or politically motivated internment and genocide especially high rates of PTSD
  - More than 1/3 to ½ of those exposed develop PTSD
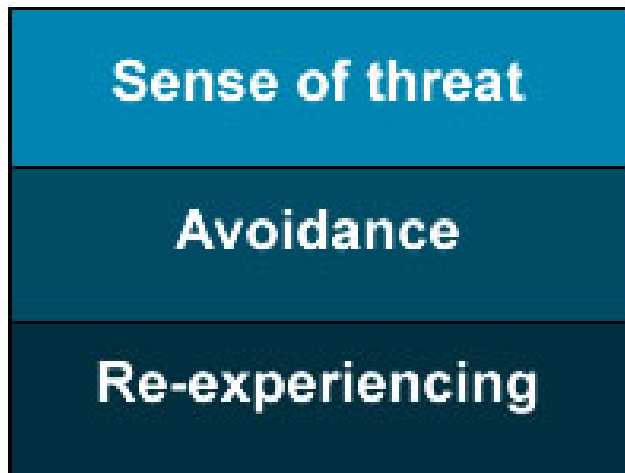
Complex Trauma

- Not a DSM 5 diagnosis

- Sometimes also referred to as

  - Complex developmental trauma or developmental trauma disorder (if in children)

  - Complex PTSD

  - Disorders of extreme stress

- Found in people who have experienced multiple, chronic or prolonged traumas
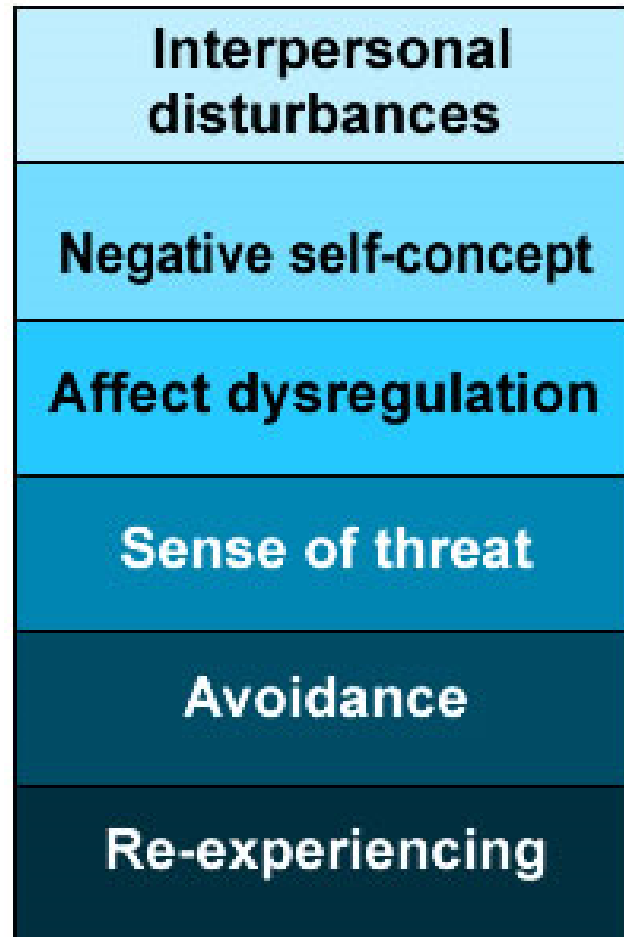
Complex Trauma-2

- Often present with symptoms that don't fit into DSM 5 categories
  - Dissociation, anger, depression, change in self concept, change in response to stressful events
  - Dysregulation of multiple symptom domains   Body-sensory and motor
    - Affect-explosive/irritable or frozen/restricted
    - Cognition-flashbacks, dissociation, altered perceptions/beliefs
    - Behavior-regression (in children)
- Can be misdiagnosed e.g., as borderline PD

PTSD and complex PTSD symptoms

source: European Journal of Psychotraumatology 2013, 4: 20706
http://dx.doi.org/10.3402/ejpt.v4i0.20706

PTSD:
Sense of threat
Avoidance
Re-experiencing

Complex PTSD:
Interpersonal disturbances
Negative self-concept
Affect dysregulation
Sense of threat
Avoidance
Re-experiencing

http://traumadissociation.com/complexptsd

Treatment of Trauma

- Make systems trauma informed

- Trauma-Specific Treatment

- Traditional or culturally-based healing

- Increase attachment/ social/community support

Trauma-Specific Treatments

- Trauma focused cognitive behavioral therapy (CBT)
- Dialectical Behavioral Therapy (DBT)
- Eye movement desensitization and reprocessing (EMDR)
- Tapping
- Prolonged Exposure
- **Treatment for historical trauma e.g. HTUG**
- Psychodynamic therapy
- Pharmacotherapy
- Traditional healing

Trauma-Specific Treatments-continued

- Body therapies "sensorimotor"
  - Breathing techniques
  - Acupuncture
  - Exercise
  - Rhythmic activities- drumming, dancing
  - Mindfulness meditation
  - Massage
  - Neurosequential model of therapeutics
  - Hakomi therapy
  - Equine therapy

HTUG Development & the Takini Network/Institute 1980s-2017

Tunkasila Tatanka Iyotake, Mother Her Holy Door, Daughter, and Grandchild

Historical Trauma and Unresolved Grief Intervention

- HTUG facilitates: (1) not being alone in depression; (2) reduction of stigma through the emphasis on the collective context (3) decrease in depression;

- Research team members/providers dealing with own HT and ongoing family and community trauma;

- Traditional tribal culture as protective factors;

- Participants' testimonies of perceived positive response to interventions and not having had an opportunity to address HT before

Historical Trauma Intervention Research & Evaluation: Qualitative Evaluation of Parental Responses

- **Increased sense of parental competence**

- **Increase in use of traditional language**

- **Increased communication with own parents and grandparents about HT**

- **Improved relationships with children, parents, grandparents, and extended kinship network**

- **Increased pride in being Lakota and valuing own culture, i.e. Seven Laws**

Summary

- There are several types of trauma

    - **Historical trauma** involves cumulative emotional and psychological wounding from massive group trauma across generations

    - **Complex trauma** involves exposure to prolonged or multiple trauma, and complex symptoms that may not meet DSM 5 criteria

    - **Vicarious trauma** involves prolonged exposure to others' trauma, and may lead to compassion fatigue and/or burnout

Trauma informed care

Polling Question 4

- How knowledgeable are you about Trauma Informed Care?

1. Not at all

2. A little

3. A fair amount

4. A lot

What is Trauma Informed Care?

- Trauma Informed Care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma.

- Trauma Informed Care also emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment.

http://www.traumainformedcareproject.org/

Trauma Informed Care Does Not Mean...

- Just being nicer

- Permitting unacceptable or unsafe behavior

- Just changing clinical care

Trauma Informed Care Is…

- Recovery oriented

- Patient/client/consumer driven

- Involves cultural humility/co-learning

- Provides trauma specific services

SAMHSA- Trauma Informed Approach

- Realizes the widespread impact of trauma and paths for recovery

- Recognizes the signs and symptoms of trauma in patients, families, staff, and others

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

- Seeks to actively resist re-traumatization*

Standard Human Services Paradigm

- Primary goal of services are stability and the absence of symptoms or social problems, not patient wellness

- Services crisis driven

- Focused on acute problem(s)

- Time limits of visits, services driven by financial and administrative needs (not patient needs)

- Medical model

- Problems attributed to the individual, limited focus on social context

- Problems treated in separate service systems, not integrated

Human Services Relationship

Standard

- Hierarchical
- Trust is assumed
- Safety is assumed

- Patient is passive recipient of services (or chooses from a menu)

Trauma-Informed

- Collaborative
- Trust is developed over time
- Steps are taken to ensure safety
- Patient is encouraged/skills developed to express choice

What is Historical Trauma Informed Care?

- Understanding the importance of cross generational and ancestral ties in tribal communities and families

- Addressing cultural norms for addressing trauma and healing, traditional bereavement

- Examining the collective traumatic tribal history as well as traditional cultural wisdom and resilience

Why Institute Trauma Informed Care?

- Benefits
  - Better clinical care for all patients
  - Improves patients' adherence with visits/treatment
  - Better health outcomes for our patients
  - Improves health and wellness of clinicians
  - Improves the working environment for clinicians, staff, and management
  - Improves clinicians' ability to understand and/or work with the community

5 Principles of Trauma-Informed Care
(modified from CCTIC)

- Safety

- Trustworthiness
  - Making tasks clear
  - Maintaining appropriate boundaries

- Choice
  - Prioritizing consumer choice and control

- Collaboration
  - Between clinicians and consumers
  - Emphasizing working together on goals, not top down

- Encouragement
  - Recognizing strengths
 - Skill building

Creating a Safe Context-Physical Safety

- How is physical safety of patients and staff ensured?

  - Physical space

  - Who is allowed to come there

  - When and where are services offered

- ***Provide culturally appropriate symbols of safety in the physical environment.*** These include paintings, posters, pottery, and other room decorations that symbolize the safety of the surroundings to the client population. Avoid culturally inappropriate or insensitive items in the physical environment.

Historical Trauma
& Unresolved Grief Interventions:
Return to the Sacred Path
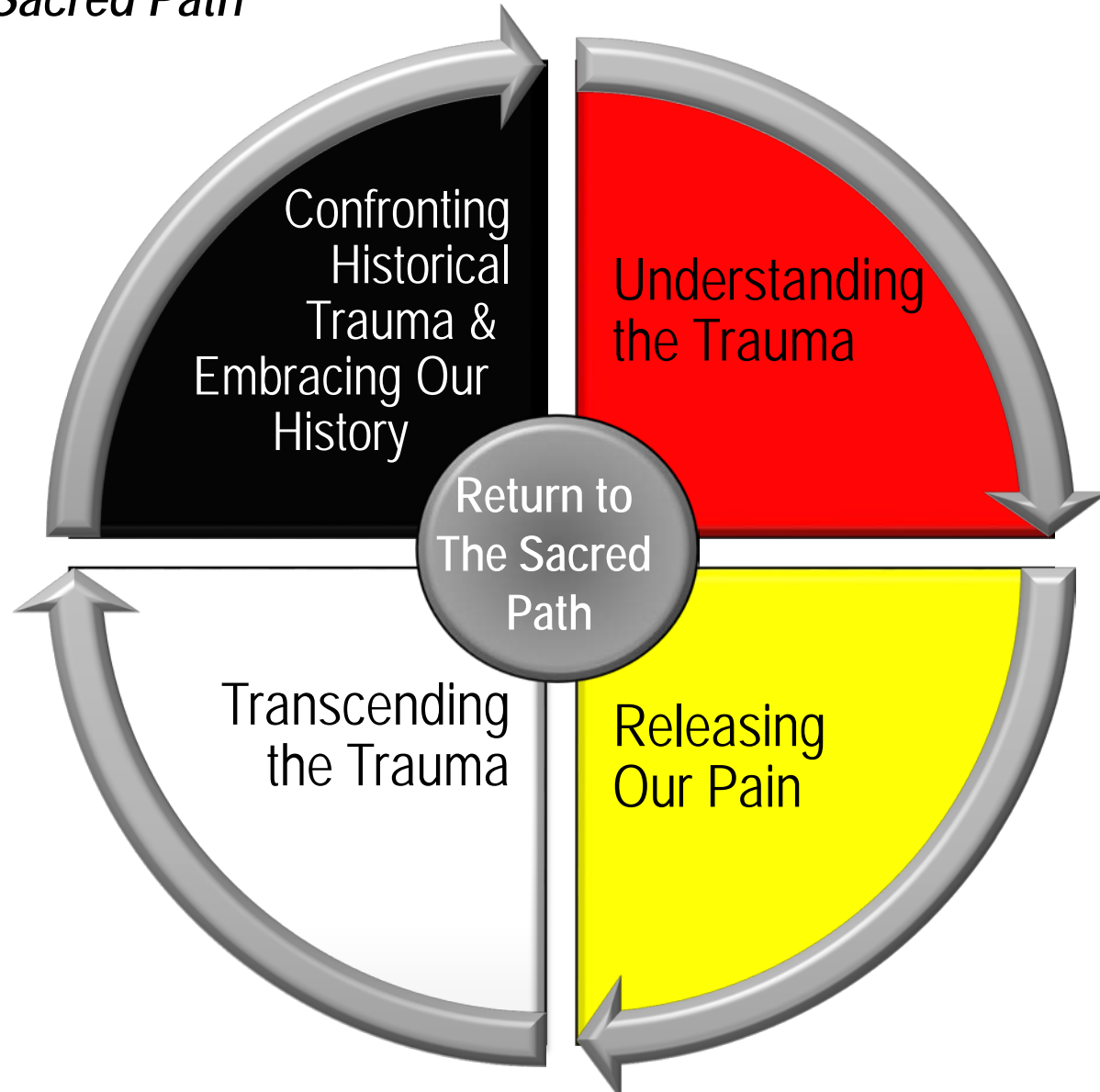
Creating a Safe Context-Emotional Safety

- Are staff, patients, and providers able to speak up?

- Is the system/people in it perceived as trustworthy?

  - How are patients greeted at the door?

  - Are boundaries clear and consistent?

  - Transparency

  - Confidentiality

  - Predictability

Ways to Help Sense of Emotional Safety

- Calm, slow voice

- Non judgmental language

- Explain need for obtaining sensitive information

- Ensure private space for interview/examination

- Consider patient's physical/emotional boundaries

- Consider touch-it might be triggering

Language Has Meaning

- Consumer, client, patient, relatives
- First name, last name
- Trauma survivor, cancer survivor, incest survivor
- Doctor, physician, clinician, therapist, counselor, provider, prescriber
- Empowerment, encouragement
- Control
- The way we talk to patients
  - Open ended versus close ended questions
  - "You shouldn't, you can't"

Culturally & Historically Responsive Assessment

- Explore generational boarding school history, tribal traumatic events, and investigate how these were/are processed in the family

- Explore degree of involvement in traditional Indigenous culture; complexity of cultural responsiveness is examined in literature on assessment and intervention with Indigenous populations (e.g. Brave Heart, 2001 a, b).

- Consider tribal relocations, migration, trauma in tribal community of origin, language

Trauma Informed Reminders

- Trauma reactions can be triggered by sudden loud sounds, tension between people, certain smells, casual touches

- Exposing one's history can manifest in the client as feeling vulnerable and unsafe.

- Sudden treatment transitions or changing provider, can evoke feelings of abandonment

- Trauma survivors generally value routine and predictability.

- Strive to maintain a soothing, quiet demeanor. Clients who have been traumatized may be more reactive even to benign or well-intended questions.

Choice

- Are patients able to choose
  - Their treatment provider?
  - Time/date of follow up appointments?
  - Type of treatment?
  - Who comes to appointments with them?
  - Location of services?
  - Emergency management?
- How can we maximize patient choice?

Collaboration

- How can we do with rather than do for or do to?

- Are treatment plans decided upon collaboratively?

- Is patient feedback incorporated into the treatment?

- Encourage patient to collaborate

- Develop peer support services

- Involve peers in the organizational structure

Encouragement

- How do our services recognize patients strengths and build patients' skills?

- What is their understanding of what they need/what service are they seeking?

Staff Support and Well-Being

- Support and care for entire staff

- Follows the same 5 principles as used with patients:
  - Safety, trustworthiness, choice, collaboration, encouragement

- In order to care for others we need to function well ourselves
  - Able to teach, role model, not be reactive, self-controlled, never abuse power
  - Minimize vicarious/secondary trauma

Community Partnerships

- Form partnerships between your agency and the community
  - Police
  - First responders
  - Other medical and behavioral health organizations
  - Spiritual leaders, healers, churches
- Part of trauma informed care
- Promotes safe communities
- Decreases trauma in communities

Culture Shift

- Incorporate knowledge about trauma into all aspects of services

  - Not just for patients we know have experienced trauma

- Minimize re-victimization

  - Do no harm/ non maleficence

  - Awareness that the service system (IHS, medical, dental) has been re-traumatizing to people

Polling Question 5

- How Trauma Informed is Your Place of Work?

1. Not at all

2. Somewhat

3. A fair amount

4. Very

Steps to Creating a Trauma Informed System

- Culture shift
  - Not just new information or services
  - New way of thinking and acting
- Involves everyone: administrators, supervisors, line staff, clinicians, patients, families
- Begin with small steps
- Use the same principles we use with patients

Upcoming Events

- Four 3 part webinar series to follow
  - For healthcare providers
  - For behavioral health clinicians
  - For non-clinical staff
  - For administrators
- Learning collaboratives/case consultations
  - For healthcare providers (with Jeanne Bereiter)
  - For behavioral health clinicians (with Maria Yellow Horse Brave Heart)

Websites

- ACES Connection

http://www.acesconnection.com/

- ACES Too High

www.acestoohigh.com

- International Society for Traumatic Stress Studies (ISTSS)

www.istss.org

- The National Council for Behavioral Health

https://www.thenationalcouncil.org/topics/trauma-informed-care/

- National Child Traumatic Stress Network (NCTSN)

http://www.nctsn.org/

Websites-continued

- PTSD: National Center for PTSD (US Department of Veterans Affairs)

https://www.ptsd.va.gov/

- SAMHSA National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint (NCTIC)

https://www.samhsa.gov/nctic

- SAMHSA National Child Traumatic Stress Initiative (NCTSI)

https://www.samhsa.gov/child-trauma

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