Understanding the Impact of Trauma and the Need for An Organizational Approach to Trauma-Informed Care

Andrew Kurtz, MFT
12/11/2019
Working with communities to address the opioid crisis.

- SAMHSA’s State Targeted Response Technical Assistance (STR-TA) grant created the *Opioid Response Network* to assist STR grantees, individuals and other organizations by providing the resources and technical assistance they need locally to address the opioid crisis.

- Technical assistance is available to support the evidence-based prevention, treatment, and recovery of opioid use disorders.
Working with communities to address the opioid crisis.

✨ The Opioid Response Network (ORN) provides local, experienced consultants in prevention, treatment and recovery to communities and organizations to help address this opioid crisis.

✨ The ORN accepts requests for education and training.

✨ Each state/territory has a designated team, led by a regional Technology Transfer Specialist (TTS), who is an expert in implementing evidence-based practices.
Contact the Opioid Response Network

✧ To ask questions or submit a technical assistance request:

- Visit www.OpioidResponseNetwork.org
- Email orn@aaap.org
- Call 401-270-5900
Funding for this initiative was made possible (in part) by grant no. 6H79TI080816 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.
Approach: To build on existing efforts, enhance, refine and fill in gaps when needed while avoiding duplication and not “re-creating the wheel.”
Overall Mission

To provide training and technical assistance via local experts to enhance prevention, treatment (especially medication-assisted treatment like buprenorphine, naltrexone, and methadone), and recovery efforts across the country addressing state and local - specific needs.
Understanding the Impact of Trauma and the Need for An Organizational Approach to Trauma-Informed Care

Andrew Kurtz, MFT

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What we’ll cover

• Understanding the brain

• Review definitions of trauma

• Develop understanding of the relation between trauma and substance use

• Identify opportunities to enhance client engagement using a trauma-informed approach
• TIP 57 on enhancing trauma-informed care in behavioral health settings
• Available on store.samhsa.gov
Co-Occurring Disorders Patients

- Use greater treatment resources
- Have a more complicated course
  - Higher rates of relapse
  - Higher rates of re-hospitalization
  - More frequent ER visits
  - Violence, suicide, homelessness
  - Increased morbidity and mortality
- Poorer treatment compliance
- More contact with criminal justice
- Experts in this field assert that co-occurring disorders should be the expectation, not the exception in any behavioral health setting.
Adverse Effects of Co-Occurring Disorders

- People with CODs are less likely to have stable housing compared to those with SMI alone (Drake & Brunette, 1998).
  - 50 – 70% of people who are homeless and have a mental health disorder also have a substance use disorder (Padgett, Gulcur, & Tsemberis, 2006).

- Clients with SMI have significantly poorer employment outcomes, including lower total earnings, fewer hours worked, and less competitive work (Cook et al., 2007).
  - There’s mixed evidence that co-occurring SU exacerbates these challenges, however, achieving competitive employment can significantly increase the likelihood for stable recovery (Becker, Drake, & Naughton, 2005).
How Serious are Co-occurring Disorders?

• COD Clients require more complex and expensive care.
• COD Clients tend to have more problems of all kinds (medical, legal, social, interpersonal, homelessness, etc.), and more (and more expensive) contacts with agencies and providers (mental health, drug & alcohol, law enforcement, courts, emergency rooms, social welfare, shelters, etc.).
• Clients with co-occurring disorders tend to “fall through the cracks” of the traditional treatment system and develop even worse and more expensive problems.
What is Trauma?
DSM Criteria

- DSM-5 Criteria:
  - Exposure to actual or threatened death, serious injury, or sexual violence
    - For adults, includes repeated exposure to details
    - For children, includes events occurring to caregiver
  - Four clusters of symptoms
    - Intrusive symptoms
    - Avoidance
    - Negative alterations to mood or cognition
    - Changes in arousal/reactivity
  - Additional considerations (duration, impairment)
Who experiences trauma?

• 61% of men and 51% of women report experiencing or witnessing a trauma in their lifetime

• Natural disaster or experiencing life-threatening accident ranked highest

• Second study found:
  – 71.6% reported witnessing trauma
  – 30.7% experienced a trauma resulting in injury
  – 17.3% reported psychological trauma

(Kessler et al, 1999) (El-Gabalawy, 2012)
Types of Traumas

- Individual
- Group, community, and culture trauma
- Historical trauma
- Mass trauma
- Interpersonal trauma
- Developmental trauma
- Systems-oriented trauma
Review of Trauma

- 3 types of stressors
  - Positive → helping to guide growth
  - Tolerable → not helpful, but not causing lasting harm
  - Toxic → sufficient to overcome one’s coping mechanisms and lead to long-term impairment
Review of Trauma

BIG T

- War
- Disasters
- Childhood sexual abuse
- Physical abuse
- Car wreck
- Crime victimization
- Witnessing death
- Domestic violence

little t

- Emotional abuse
- Neglect
- Failure experiences
- Phobia related experiences
- Losses
- Stress at work or school
- Bullying
- Domestic violence
Moving from “what’s wrong with you” to “what happened to you.”
What is Trauma-Informed Care?

Trauma-Informed

- Recognition of high prevalence of trauma
- Recognition of primary and co-occurring trauma diagnoses
- Recognition of culture and practices that are re-traumatizing

Non Trauma-Informed

- Lack of education on trauma prevalence and universal precautions
- Over-diagnosis of schizophrenia, bipolar d/o, conduct d/o, singular addictions
- Cursory or no trauma assessment
- “Tradition of Toughness” as best care approach
What is Trauma-Informed Care?

**Trauma-Informed**
- Power/control minimized – constant attention to culture
- Caregivers/supporters - collaboration
- Address training needs of staff to improve knowledge & sensitivity

**Non Trauma-Informed**
- Staff demeanor, tone of voice
- Rule enforcers – compliance is key
- “Patient blaming” as fallback position without training
What is Trauma-Informed Care?

Trauma-Informed
- Staff understand function of behavior
- Objective, neutral language
- Transparent systems open to outside parties

Non Trauma-Informed
- Behavior seen as intentionally provocatively
- Closed system – advocacy discouraged
Trauma-Informed Organizations

• Safe, calm and secure environment with supportive care
• System wide understanding of trauma prevalence, impact and trauma informed care
• Cultural Competence
• Consumer voice, choice and self-advocacy
• Recovery, consumer-driven and trauma specific services
• Healing, hopeful, honest and trusting relationships

How does your organization measure up?

Organizational Adoption of TIC

1. Early screening and assessment of trauma
2. Consumer driven care and services
3. Trauma-informed, educated and responsive workforce
4. Provision of trauma-informed, evidence-based, and emerging practices
5. Create safe and secure environments
6. Engage in community outreach and partnership building
7. Ongoing performance improvement and evaluation

The ACE Study
Adverse Childhood Experiences Study (ACE)

- Ongoing collaborative research between the CDC and Kaiser Permanente
- Over 17,000 Kaiser patients participating in routine health screening volunteered to participate in the study
- Data reveal staggering proof of the health, social, and economic risks that result from childhood trauma

The ACE Questionnaire

- Verbal or emotional intimidation/abuse
- Physical abuse/hitting
- Sexual abuse
- Emotional neglect/feeling unloved or unsupported
- General neglect, basic needs not met

- Parents ever separated or divorced
- Witnessed domestic violence or abuse against a caregiver
- Household drinker or drug user
- Depressed or mentally ill household member
- Incarcerated family member

Major Findings of the ACE Study

• ACEs such as childhood abuse, neglect, and exposure to other traumatic stressors are common

• Almost two-thirds of the ACE Study participants reported at least one ACE, and more than one of five reported three or more ACE

• The short- and long-term outcomes of these childhood exposures include a multitude of health and social problems

Results of the ACE Study

The ACE Study

28% of women and 14% of men report having experienced childhood sexual abuse.

66% of people in substance abuse treatment report childhood abuse or neglect.

90% of women with alcohol dependence reported childhood sexual abuse or severe physical abuse.
What Happens Later in Life?
The ACE Score – Risk for Health Problems

- **Alcoholism and alcohol abuse**
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Fetal death
- Health-related quality of life
- **Illicit drug use**
- Ischemic heart disease (IHD)
- Liver disease

- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases (STDs)
- **Smoking**
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy

Trauma and the Brain

Child Maltreatment: A Neurodevelopmental Perspective on the Role of Trauma and Neglect in Psychopathology
Bruce D. Perry, M.D., Ph.D
John Wiley & Sons, Hoboken, NJ, 2008 pp. 93

3 Year Old Children

Normal

Extreme Neglect

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Continuing Brain Development

<table>
<thead>
<tr>
<th>At Birth</th>
<th>6 Years Old</th>
<th>14 Years Old</th>
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Early in development, synapses are rapidly created and then pruned back. Children’s brains have twice as many synapses as the brains of adults.

Brain Development
Ages 5-20 years

- MRI scans of healthy children and teens compressing 15 years of brain development (ages 5–20).
- Red indicates more gray matter, blue less gray matter.
- **Neural connections are pruned** back-to-front.
- The prefrontal cortex ("executive" functions), is last to mature.

Information taken from NIDA’s Science of Addiction
http://www.drugabuse.gov/ScienceofAddiction/

Trauma and the Brain

SOURCE: Bremner, 2006
Trauma and the Brain

- Affects hippocampus and amygdala development
- Traumatized individuals “bypass” the prefrontal cortex when triggered
- During development, impaired growth in left hemisphere contributes to depression
- Impaired connection between hemispheres

SOURCE: BA van der Kolk, 2003
What fires together, wires together

- Neurons firing act like an electrical current travelling down the axon
- Under the right conditions, synaptic connections can be strengthened by firing
- Repetition, emotional arousal, novelty, careful focus of attention
- Initially, very few connections exist
- Early experiences will shape the way in which you perceive the world and react to stressors
The Impact of Trauma

- Neuroplasticity
- Recovery from PTSD involves controlling or inhibiting the fear response
- New contradictory information can be introduced ("I am safe") that will begin to lessen the fear over time as new information is integrated
Neuroplasticity

• If early experiences are positive, chemical controls over how genes are expressed will further reinforce emotional resilience

• If early experience are negative, alterations in genes result in difficulty with regulation and stress response resulting in reduce resilience

• Repeated neural firing plays a role in protein production, gene expression and subsequent firing

SOURCE: Siegel, 2010
The Impact of Trauma

- Exposure to traumatic reminders increases blood flow to orbitofrontal cortex, insula, amygdala, and anterior temporal lobe, left anterior prefrontal cortex.

- Triggers activate brain regions that support intense emotions, while decreasing activity of brain structures involved in the inhibition of emotions and the translation of experience into communicable language.
The Impact of Stress

- Stress impacts the entire body
- The impact can last beyond the stressful event
- Stress can exacerbate mental health issues
- Stress can exacerbate substance use issues
- Stress can exacerbate medical conditions
- ....and vice versa
The Vagus Nerve

- Trauma and the way “the body keeps score” (van der Kolk)
- Connects the brain to stomach, gut, heart, lungs, throat
- Increased arousal results in physical symptoms and exacerbation of medical symptoms
- Communication between brain and immune systems for health and illness
- Composed of over 80% sensory fibers that constantly communicate information to and from brain
- Yoga and mindfulness activities are being examined to enhance mind-body therapies

SOURCE: Taylor et al, 2010; Porges, 2011
The Physiological Impact of Stress

- Stress impacts the nervous system
- Autonomic nervous system (ANS): divided into the parasympathetic (PNS) and sympathetic nervous systems (SNS)
- When the body is stressed, the sympathetic nervous system activates and prepares the body for action (fight or flight)
- SNS signals adrenal glands to release cortisol and adrenalin
- Heart beats faster, respiration increases, blood vessels dilate, digestion changes, and glucose levels increase
- Parasympathetic system allows functioning to return to normal
- Stress increases SNS activation and an elevated and prolonged arousal state

SOURCE: APA, 2016
ACEs and Violence

• Minnesota Student Survey found that adolescent males were 35%-144% more likely to engage in violence for each ACE endorsed
• Males were 45x more likely to engage in intimate partner violence when reporting childhood sexual abuse
• Individuals in corrections are 4x as likely to have experienced 4+ ACEs
ACEs and Criminal Justice

- A criminal psychologist administered the ACEs study to over 100 convicted killers
- The average score reported to him was 8
- Only 1 in 1000 Americans has an ACE score of 8 or higher

- A study of 152 adolescent offenders found that over 90% indicated having experienced at least one traumatic event
- 33.6% indicated having experienced 8 or more
A Trauma-Informed Approach
NIDA Clinical Trials Study

- Purpose was to improve PTSD and SUD symptoms among women in an outpatient setting
- One group received trauma-focused interventions
- Reductions in PTSD were more likely to be associated with substance use improvement
- The opposite was not true

The Impact of Trauma

Trauma is like a rock hitting the water’s surface
Emotional reactions

• What it looks like
  – Numbness or detachment
  – Anxiety or fear
  – Guilt
  – Anger
  – Helplessness
  – Sadness/shame
  – Depersonalization
  – Lack of control
  – Irritability or depression
  – “Stockholm syndrome”

SOURCE: SAMHSA, 2014
Physical reactions

• What it looks like
  – Nausea
  – Sweating
  – Faintness
  – Skin rash
  – Fatigue or exhaustion
  – Aches and pains
  – Hyperarousal
  – Greater startle response
  – Appetite changes
  – Nightmares/difficulty sleeping

SOURCE: SAMHSA, 2014
Cognitive reactions

• What it looks like
  – Difficulty concentrating
  – Rumination/preoccupation or racing thoughts
  – Self-blame
  – Difficulty making decisions
  – Generalization of triggers
  – Memory problems
  – Intrusive thoughts/flashbacks
  – Distortion of time and space (immediate reaction)
  – Belief that feelings/memories are dangerous
  – Hallucinations and delusions

SOURCE: SAMHSA, 2014
Behavioral reactions

• What it looks like
  – “Jumpy” or easily startled
  – Restlessness
  – Argumentative behavior
  – Difficulty expressing oneself
  – Self-harm, adoption of risky/self-destructive behaviors
  – Withdrawing
  – Fixed or “glazed” eyes
  – Sudden flattening of affect
  – Stereotyped movements
  – Responses not congruent with the present context or situation
  – Excessive intellectualization

SOURCE: Briere, 1996a
- Numbness or detachment
- Anxiety or fear
- Guilt
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- Hallucinations and delusions
- Self-blame
Behavioral Coping

• Interventions
  – Focused breathing
  – Mindfulness/meditation
  – Progressive muscle relaxation
  – Establishing a safe environment
  – Listening to music
  – Grounding techniques

SOURCE: SAMHSA, 2014
Grounding techniques

• Ask the client to state what he/she observes
  – “You’re in a safe situation. Let’s try to stay in the present. Take a slow deep breath, relax your shoulders, put your feet on the floor; let’s talk about what day and time it is, notice what’s on the wall, etc. What else can you do to feel okay in your body right now?”

• Help the client decrease the intensity of affect
  – Imagine turning down an “emotional dial”, progressive muscle relaxation

• Distract the client from unbearable emotional states
  – Counting tasks, focusing on objects in the room, self-talk to remind of current safety, focus on recent or future events (“to-do” list for the day)

• Ask the client to use breathing techniques

SOURCE: SAMHSA, 2014
Affective Coping

• Interventions
  – Feeling identification
  – Role playing expression of feelings with others
  – Thought interruption
  – Positive imagery
  – Positive self-talk
  – Problem solving
  – Recognition of triggers

SOURCE: SAMHSA, 2014
Cognitive Coping

• Interventions
  – The Cognitive Triangle and anticipating outcomes
  – Enhance personal safety
  – Challenging negative cognitions

• “I can only be happy if I’m involved with someone.”
• “Being strong means I should never feel upset.”
• “Some problems have to be avoided because they are just too hard to handle.”
• “I can’t handle how horribly wrong everything is going in life.”

Views about the world
“Things will never be the same”
“What is the point? I will never get over this”
“It is hopeless”

Views about self
“I am incompetent”
“I should’ve reacted differently”
“It is too much for me to handle”
“I feel damaged”

Views about the world
“The world is a dangerous place”
“People cannot be trusted”
“Life is unpredictable”

SOURCE: SAMHSA, 2014
Cognitive Coping

• Interventions
  – The Cognitive Triangle and anticipating outcomes
  – Enhance personal safety
  – Challenging negative cognitions

Views about self
“I am incompetent”
“I should’ve reacted differently”
“It is too much for me to handle”
“I feel damaged”

Views about the future
“Things will never be the same”
“What is the point? I will never get over this”
“It is hopeless”

Views about the world
“The world is a dangerous place”
“People cannot be trusted”
“Life is unpredictable”

Problem: Someone is starting an argument with me.
1. Ask them to please back off.
   1. ? 1. ?
2. Yell at him
   2. He gets mad; might cause a fight 2. Bad outcome
3. Hit him
   3. Get arrested, get beaten up, get killed 3. Really bad outcome

SOURCE: Cohen et al, 2006
Exposure therapy

• Interventions
  – Constructing a trauma narrative
  – Builds on all other coping techniques

SOURCE: SAMHSA, 2014
Coping/Soothing Kit

**Goal:** for trauma survivors to try new healthy coping skills and to enhance grounding when triggered.

- Sweet candy
- Stress ball
- Relaxing/calming music
- Bubbles (control breathing)
- Relaxing bath/lotions
- Non-caffeine tea
- Sour candy
- Mazes/word puzzles
- Drawing
- Word Search book
- Play-doh
- Humorous movies
- Sewing, knitting
Seven Domains of a Trauma-Informed Organization

- Domain 1: Screening and Assessment
- Domain 2: Consumer-Driven Services and Policies
- Domain 3: Workforce Development
- Domain 4: Best Practices
- Domain 5: Safety and Environmental Assessment
- Domain 6: Community Outreach
- Domain 7: Evaluation Data

Domain 2: Consumer-Driven Services and Policies

Rate each statement on a scale of 1-5

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<tbody>
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<td>Agree</td>
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</table>
1. The needs and concerns of current program consumers are addressed in community meetings.

2. The program provides opportunities for consumers to lead community meetings.

3. Current consumers are involved in the development of program activities.

4. Current consumers are given opportunities to evaluate the program and offer their suggestions for improvement in anonymous and/or confidential ways (e.g., suggestion boxes, regular satisfaction surveys, meetings focused on necessary improvements, etc.).

5. Former consumers are hired at all levels of the program.

6. The program recruits former consumers for their board of directors.

7. Former consumers are involved in program development.

8. Former consumers are involved in providing services (e.g., peer-run support groups, educational, and therapeutic groups.).
Domain 3: Workforce Development

Rate each statement on a scale of 1-5

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1. Staff members have regular team meetings.

2. Topics related to trauma are addressed in team meetings.

3. Topics related to self-care are addressed in team meetings (e.g., vicarious trauma, burn-out, stress-reducing strategies).

4. Staff members receive individual supervision from a supervisor who is trained in understanding trauma.

5. Part of supervision time is used to help staff members understand how their stress reactions impact their work with consumers.

6. The program helps staff members debrief after a crisis.

7. The program provides opportunities for on-going staff evaluation of the program.

8. The program provides opportunities for staff input into program practices.

9. Outside consultants with expertise in trauma provide on-going education and consultation.
Domain 4: Best Practices

Rate each statement on a scale of 1-5

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1. What traumatic stress is.
2. How traumatic stress affects the brain and body.
3. The relationship between substance use and trauma.
4. The relationship between childhood trauma and adult re-victimization (e.g., domestic violence, sexual assault).
5. Cultural differences in how people understand and respond to trauma.
6. How working with trauma survivors impacts staff.
7. How to help consumers identify triggers (i.e., reminders of dangerous or frightening things that have happened in the past).
8. How to help consumers manage their feelings (e.g., helplessness, rage, sadness, terror, etc.).
9. De-escalation strategies (i.e., ways to help people to calm down before reaching the point of crisis).
10. How to establish and maintain healthy professional boundaries.
Domain 5: Safety and Environmental Assessment

Rate each statement on a scale of 1-5

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1. The program facility has a security system (i.e., alarm system).
2. Program staff monitors who is coming in and out of the program.
3. Staff members ask consumers for their definitions of physical safety.
4. The environment outside the program is well lit.
5. The common areas within the program are well lit.
6. Bathrooms are well lit.
7. Consumers can lock bathroom doors.
8. The program incorporates child-friendly decorations and materials.
9. The program provides a space for children to play.
10. The program provides consumers with opportunities to make suggestions about ways to improve/change the physical space.
Avoiding Crises in Trauma Care: Organizational Recommendations

1. Avoid triggers

2. Prepare clients for what to expect and respond to initial, intense emotions (including at the end of treatment)

3. Provide a direct contact and accessible mobile technology for clients

4. Hire effective staff. And then ensure they’re trained and supported
Goals in Trauma-Informed Care

• Recognize that trauma-related symptoms and behaviors originate from adapting to traumatic experiences
• View trauma in the context of the individual’s environments
• Minimize the risk of retraumatizing, replicating prior trauma dynamics
• Create a safe environment
• Identify trauma as a primary goal

SOURCE: SAMHSA, 2014
Develop a Trauma-Informed Plan

- Discuss their initial recall or first suspicion that they were having a traumatic response.
- Become educated on trauma responses.
- Draw a connection between the trauma and presenting trauma-related symptoms.
- Explore their support systems and fortify them as needed.
- Understand that triggers can precede traumatic stress reactions, including delayed responses to trauma.
- Identify their triggers.
- Develop coping strategies to navigate and manage symptoms.

SOURCE: SAMHSA, 2014
Providing Psychoeducation on Trauma

• Strategy #1: Provide psychoeducation on the common symptoms of traumatic stress

• Strategy #2: Research the client’s most prevalent symptoms specific to trauma, and then provide education to the client. (Ex: individual who was trapped as a result of a traumatic event will more likely be hypervigilant about exits, plan escape routes even in safe environments, and have strong reactions to interpersonal and environmental situations that are perceived as having no options for avoidance or resolution)
Providing Psychoeducation on Trauma

• Strategy #3: List symptoms. After each symptom, ask the client to list the negative and positive consequences of the symptom.
A Trauma-Informed Approach to Engagement

Open ended questions to recognize and focus on building an individual’s strengths:

• What are some of the accomplishments that give you the most pride?
• What would you say are your strengths?
• How do you manage your stress today?
• What behaviors have helped you survive your traumatic experiences?
• What are some ways that you deal with painful feelings?
• What coping tools have you learned from your ______ (fill in: cultural history, spiritual practices, friends, family, etc.)?
Additional Trauma-Specific Interventions

• Cognitive processing therapy
• EMDR
• Skills Training in Affective and Interpersonal Regulation (STAIR)
• Stress inoculation training (SIT)
• Addiction and trauma recovery integration model (ATRIUM)
• Beyond Trauma: A Healing Journey for Women
• Concurrent Treatment of PTSD and Cocaine Dependence (CTPCD)
• ICBT
• Seeking Safety
• Substance Dependence PTSD Therapy
• Trauma Affect Regulation: Guide for Education and Therapy (TARGET)
• Trauma Recovery and Empowerment Model (TREM)

SOURCE: SAMHSA, 2014
Self-Care: Recognizing Burnout

• **Burnout**: exhaustion of physical or emotional strength and motivation usually as a result of prolonged stress or frustration, powerlessness, inability to achieve one’s goals

• **Compassion Fatigue**: the loss of caring for others’ emotional pain. Similar to PTSD, except it applies to those emotionally affected by the traumas of others

• **Vicarious (secondary) Trauma**: similar to compassion fatigue, places the focus on the emotional impact of highly traumatized patients on the therapist. Symptoms nearly identical to PTSD
Self-Care: Recognizing Burnout

- Symptoms of burnout
  - Procrastination
  - Chronic fatigue
  - Cynicism
  - Blaming others
  - Chronic lateness
  - Difficulty experiencing happiness
  - Pessimism
  - Loss of satisfaction in career
  - Giving up on: education, occupation, friendships, marriage, living
  - Addictive behaviors
  - Frequent illness
Self-Care: Recognizing Burnout

• Assessing your Burnout:
  – What populations do you work with?
  – Who/what are your organizational supports?
  – What are your familiar coping strategies?
  – What is your emotional style?
  – What are your vulnerabilities?

It is always critical to seek help and support if you recognize symptoms related to burnout as they could indicate the need for more formal support though your own counseling, EAP, etc.
Self-Care: Develop a Plan

• **Personal**: tending to physical needs (adequate rest, nutrition), participating in fun activities, identifying relaxing activities to engage in regularly

• **Professional**: obtain ongoing professional development, recognition by organization of the process of vicarious trauma, developing a professional support network
Self-Care: Develop a Plan

- Eat regularly
- Eat healthy
- Exercise
- Seek regular medical check-ups and care when needed
- Do something you enjoy
- Get enough sleep
- Take time off
- Read for fun
- Identify ways to reduce stress
- Listen to your thoughts, feelings
- Find activities that increase your curiosity
THANK YOU!!

Andrew Kurtz, MFT
askurtz@mednet.ucla.edu

For additional information on this or other training topics, visit:

www.psattc.org
www.motivationalinterview.org
www.uclaisap.org