

"Man is disturbed not by things, but by the views he takes of them."
Epictetus First century A.D. wrote in the Enchiridion

Shakespeare, many centuries later, rephrased this thought in Hamlet:
"There's nothing good or bad but thinking makes it so."

Mitigating the Risks of Re- traumatization During Hospitalization

Presenter: Deborah Saper



The Cafeteria



We all experience it through the senses but sometimes the response is visceral and outside of the here and now:

1st Spring Day

2nd Relationship

3rd Cafeteria

4th The Glance

Yikes:

Public bathroom

Bedroom door



Everyone Does It!!



Pain: No thank you!

Deny: the chipped tooth

Minimalize: the start of a tooth ache

Distract: yourself from thinking about the the tooth until the ache subsides

Avoid: tooth pain by chewing on the other side and taking Advil

Panic: because you have to go to the dentist! The tooth is throbbing!

Cope: take an anti-anxiety medication to get yourself in the dentist chair!

Trigger: Seeing whatever it was that broke your tooth
Someone talking about going to the dentist

You receive your annual check-up and cleaning reminder in the mail!

Pain: No thank you!

Debbie's Example

Pain: No thank you!

Deny: I do not recognize a problem, I was a kid. I don't even remember. (UNTIL...)

Now I remember...(thank you CJ)

Minimalize: the cafeteria is loud and hectic

Distract: I will eat in the classroom and do my homework

Avoid: I am going to the nurse, I have an upset stomach

Panic: I am forced to go to the cafeteria, ANXIETY!

Cope: I am an independent strong person and I can eat by myself or before lunch, I will ask someone to sit with me

Trigger: 11:30 am

Reading class schedule

Hearing the crowd while approaching the cafeteria

As an adult, kids talking about their lunch time experiences

Pain: No thank you!

AHHHH Do you remember?

- What have been your triggers?
- How did you know? What did you feel?
- How long did it take to recover?
- Did the "trigger" ever go away?
- How? or...why not?





What We Know



- 51% of women reported exposure to at least one lifetime traumatic event, but majority reporting more than one traumatic event. (Kessler, et al, 1995)
- A chronic overreaction to stress overloads the brain with powerful hormones that are intended only for short-term duty in emergency situations (SAMHSA).
- •Chronic hyper-arousal – nervous system does an amazing job of preparing the individual to deal with the stress but with trauma the nervous system is informed by false or phantom-cues and misperceptions (SAMHSA).
- Re-traumatization is a situation, attitude, interaction or environment that replicates the events or dynamics of the original trauma and triggers the overwhelming feelings and reactions associated with them (Jennings).

Current Practice Flowchart

- Culture of Safety with consideration of environment and policy to ensure minimal re-traumatization
- Clinical assessment and evaluation
- Cycle of Crisis and Safety Planning
 - Baseline
 - Triggers
 - Warning Signs
 - Coping Strategies
 - Debriefing
 - Revise Crisis and Safety Plan
- Person-centered treatment planning
 - Stages of Change
 - Motivational Interviewing
 - Person-selected level of treatment- problem and goal focused (challenging)
 - Programming based on person's interest and need

What We Currently Do...2nd, 3rd, 4th Marriage



- Assess
- Evaluate
- Report
- Educate
- Plan to Distract, Avoid, De-escalate, Use coping strategies, Crisis Interventions, and Debrief
- We “engage” and “wed” ourselves to a plan...
- Assess
- Evaluate
- Report
- Educate
- Revise or “divorce” plan to correct “Treatment failure”



What Can We Do To Further Mitigate Re-traumatization

- Recognize and acknowledge how systems of care may inadvertently re-traumatize clients while the actions impact other patients and staff. Re-traumatization is usually unintentional. It is always hurtful- exacerbating the very symptoms that brought the person to receiving services (Jennings).
- Further embed Trauma Informed Care philosophy and practices throughout your serving systems. Examples: Admissions process, Approach to family, Consideration when writing or revising policy and protocol, Discharge process, Environmental evaluation and Staff care and support.
- Talk about what you are doing- as you do it – in a respectful and hope-filled way- The Operation
- Be Strength-based in language, goals and in the milieu (Delaney). When you focus on what's wrong, you cannot see what's right! Look for the resources supporting the symptomatic presentation and use them to deconstruct and rebuild a new way of thinking.

What Can We Do...Continued

- Focus on goals and objectives but when “triggered” (not at the point of violence and crisis), help the person work through and deconstruct the trigger rather than avoid it! Avoidance means it so big and powerful we must escape it! We actually strengthen a person’s misconception when only stopping at distraction, coping, and avoidance. The person would be in the Contemplation, Preparation, or Maintenance Stage of Change.
- If the person is in Pre-contemplation, after de-escalation, avoidance, distraction or debriefing, use language to construct the trigger and begin to reflect upon it.
- Treatment must be viewed as live not scheduled. Although DBT, CBT, CRT and other evidence based treatments are effective and valued, if the patient is unable to maintain scheduled treatment due to daily symptoms OR unable to apply skills and strategies learned in a live setting, the conveyor belt will continue for them.

The Next Steps:

Live Treatment

Staff Recovery and Wellness

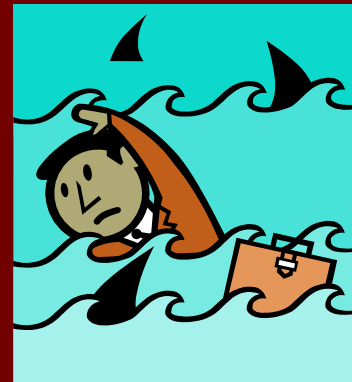
Live Treatment

- Do the work LIVE! Supportive therapy and medication are meant to prepare the person to work through the experience and develop a healthy narrative. We often neglect the most important piece of healing. The milieu and unit-living should not be separate from treatment. There is no Non-therapeutic time when people are receiving psychiatric care. The milieu and unit-living is where the skills and strategies should be supported. Persons-served recreate their realities within the context of their LIVING. The clinical work needs be there too!



Individual and Group
Treatment

Disconnect



Milieu and Unit-Living

Silent Symptoms of Trauma

- Treatment must be viewed as live not scheduled. Although DBT, CBT, CRT and other evidence based treatments are effective and valued, if the patient is unable to maintain scheduled treatment due to daily symptoms OR unable to apply skills and strategies learned in a live setting, the conveyor belt will continue for them.
- Trauma alters relations with others: It increases isolation and withdrawal; repeated search for rescuer; persistent distrust; failure to self-protect; decreases faith; and promotes a sense of despair and hopelessness (Jennings).
- These are all the issues that surface on the milieu and during unit-living.

Live Reconstruction of Reality

- Yay! We are having the baby we always wanted (construction of baby identity begins)
- Shopping, Shower, Nursery, Names (construction of baby identity is reinforced)
- We are having a boy! (construction further strengthened by contextual variables of race, class, ethnicity, religion, time in history...)
- Our baby boy arrives! (construction of identity of baby boy is implemented)
- Baby boy is developing (into who he is going to be in the context of the barriers of the construction of his identity)
- Parents adjust to the autonomy of their child (deconstructs and removes barriers and reconstructs a reality of child identity based on child's input. This can be a very challenging process with many disconnects from strength-based resources.)

Debbie's Examples

The Cafeteria: is a reminder of my resilience and ability to adapt to changing circumstances. It is also a place where I can gather with friends at work to enjoy a meal. The cafeteria is now a safe and familiar place for my children because I provide a stable and predictable life for them.

The 1st Spring Day: I have little insight into the reasons behind this uncomfortable once-a-year experience. This year, when it comes, I will "be" with it rather than "ride it out".

The Relationship: When in relationship, I will be transparent so that I can see myself within its context and challenge the misperceptions I bring to it.

The Glance: When I see "the glance", I will review and consider the person presenting it and the context in which it is presented. I will explore the possible message the "glancer" is sending and possibly have a conversation about it with the person.

Exercise in Re-writing or elaborating on meaning:

Bridge: structure over water; card game; part of an instrument;
part of your nose; closing a gap

Go back to your "Do you Remember" Slide: Did you or will you consider re-writing or elaborating on the meanings of your triggers?

Trigger 1: _____

Trigger 2: _____

Trigger 3: _____





Staff Wellness and Recovery

"You can't give what you do not have"

"One must be nurtured, balanced, and healthy to feed, stabilize, and support the healing of others"



Female Direct Care Staff Quote:

"...not very often in my 20 years of work in the field of mental health have I heard much about what happens to use, the workers. I've seen some pretty traumatic things from when I first started 20 years ago. Some of those things still haunt me that I've seen." (Jennings)

The loop must be closed.

The needs of the staff are the same as the needs of the patients. The patients need to feel safe, valued, welcomed, balanced, have opportunity to process difficult experiences and find and engage in healthy outlets (Klein; Weclaw)

Consider offering staff a vocation related process group for on-going support, opportunities to celebrate their value and contributions to the organization, provide healthy outlets to stress including an exercise venue, art and music experiences, and mindfulness and mediation opportunities.



Outcomes

When trauma informed care is implemented and applied in “the living moment” and staff receive care and support, the following occurs:

Less re-traumatization for patients

Less secondary trauma to patients and staff

Reduced assault and injury

Reduced restraint and seclusion

Length of stay or need for services decreases

Treatment HAPPENS

Trust develops

There is a reduction of stress

Moral is higher and there is an increase in staff retention

There is a decrease in staff absence and illness

(Jennings)

Reminders

SAMHSA has a tremendous amount of research regarding trauma informed care.

SAMHSA has resources, materials and tools to promote a culture of safety including the absence of violence and restraints.

Remember within alllll those hours in between therapy, groups, team meetings, and “unstructured programming” the person is perceiving reality and re-constructing meaning and relationships that support the reality and meaning that makes room for their symptoms. That is the time to DO the clinical work! You are the agent of change and “the news of difference”

A drop of red paint in a bucket of white paint changes both the red and the white paints. The colors are there but always connected to each other. Your interaction with a patient can help the person see new perspectives, elaborate and rich explanations and hope for the future. Your interactions will support the existing narrative or help the person write a healthier story. Think Pink!

Bibliography

- Delaney, K.R. (2006), Evidence Based Practice: Reduction of Restraint and Seclusion Use During Child and Adolescent Psychiatric Inpatient Treatment. *Worldviews on Evidence-Based Nursing*, 3:19-30.
- Jennings, A. (2010), Re-traumatization. Michigan's 2nd Annual Statewide Conference on Integrated Services for Individuals with Mental Health and Substance Abuse Disorders.
- Klein, J. (2011-2012), A Theory of Punishment: The Use of Mechanical Restraints in Psychiatric Care. *Social Justice*, 47.
- Wieclaw, J, Agerbo, E, Mortensen, P, Bonde, J. (2006), Risk of Affective and Stress Related Disorders Among Employees in Human Occupational and Environmental Medicine, *May*: 63 (5); 314-319

www.samhsa.gov