TRAUMA-INFORMED PRACTICE

camh Professional Practice
Inspiring Practice Excellence

Becoming BPSO

What is TRAUMA?

Trauma is an experience that overwhelms an individual's emotional and psychological ability to cope and can result in lasting mental and physical effects.

TRAUMA = EVENTS + EXPERIENCE + EFFECTS

EVENTS

- May occur once or be repeated over time

Can include:

- Actual or threatened harm
- Severe withholding of resources for healthy development

EXPERIENCE

- Same event may be experienced as traumatic by one person and not another
- Subjective experience may be influenced by a host of factors including culture, social context and developmental stage

EFFECTS

- Adverse effects may occur immediately or over time
- The connections between traumatic events and the impact of trauma may not be clear

EXAMPLES OF POTENTIALLY TRAUMATIC EVENTS

- Physical, sexual and emotional abuse
- Childhood neglect
- Severely impaired caregiver
- Forced displacement
- Cultural and intergenerational trauma
- Injuries, accidents
- Illnesses, painful medical procedures
- Natural disasters
- War, terrorism, political violence
- Experience of psychosis
- Bullying / harassment
- Intimate partner violence
- Witnessing violence (including domestic)
- Homelessness
- Abandonment
- Traumatic / multiple losses, separation, bereavement
- Betrayal of trust by caregiver
- Experience of racism, homophobia

What can be THE IMPACT OF TRAUMA?

Many areas of development and functioning can be affected by trauma.
People are affected by trauma differently; not everyone who experiences it has a lasting impact.
The mind and body are very connected in trauma experiences; responses are both physiological and psychological.

COGNITIVE

- intrusive thoughts/memories
- rigid and generalized beliefs based in danger ("I'm not safe," "the world is dangerous", "my own thoughts about the world frighten me")
- denial, confusion
- self-blame
- poor decision-making,
- poor perspective taking

INTERPERSONAL

- disrupted attachment, mistrust, fear
- problems with interpersonal boundaries
- social withdrawal / isolation

BEHAVIOURAL

- avoidance of trauma reminders
- defiance or resistance to perceived control by others
- developmental regression (i.e., physical, intellectual)
- impulses and aggression (motivated by self-protection) are difficult to manage
- risk taking
- substance use
- delinquency
- self-harming behaviours
- sexualized behaviour
- hypervigilance

LEARNING

- inattention, memory impairments, disorganization, difficulty planning
- perfectionism
- school disengagement

PHYSICAL

- disrupted physiological (e.g., metabolism) and cognitive (e.g., intellectual) maturation/processing
- increased startle response, hyperarousal
- gastrointestinal problems, headaches, fatigue, impaired immune response
- sleep disturbance
- chronic pain

ENVIRONMENTAL

- family separations, financial hardship
- social stigma

EMOTIONAL

- sadness, grief, lack of pleasure from activities
- emotional dysregulation
- anxiety, fear
- helplessness
- guilt, shame
- emotional numbing (affect is "turned off")
- difficulty reading others' emotional state

WHAT IS **TRAUMA-INFORMED PRACTICE?**

Trauma-informed practice is a broad approach to service delivery that applies the principles and practices highlighted below to all clients, regardless of trauma disclosure. Everyone in a clinical setting can practice in a trauma-informed way, even if trauma-specific treatment is not within their role.

PRINCIPLES

ACKNOWLEDGEMENT: The prevalence of trauma and the pervasiveness of its impact are acknowledged; trauma responses are an individual's attempts to cope with trauma and adapt to its impact.

SAFETY: The environment and interpersonal interactions support physical and psychological safety.

CHOICE, CONTROL & COLLABORATION: Transparent decision-making, clarity, choice and collaboration foster trust and allow clients to experience control.

STRENGTHS-FOCUSED: Recognize the client's courage and build on strengths to foster resilience.

UNIVERSALLY APPLIED: Trauma-informed practice can be applied to all clients, regardless of whether a client discloses a trauma history, or whether trauma-specific treatment is being provided.

PRACTICES

UNDERSTAND

- Understand the client in the context of their experiences and help the client do the same: "What has happened?" instead of "What is wrong?"
- Place the client's experience, coping and recovery within their cultural, social and developmental context (e.g. gender, age, socioeconomic status, education).

COLLABORATE

- Take a collaborative approach to working with the client to learn about their history and the ways it may be affecting their present life.
- Collaborate in setting treatment goals and working toward them.
- Be transparent regarding therapeutic planning, process and decision-making.

DE-ESCALATE

- Recognize when the client may be in a triggered state and be aware that feelings of safety must be re-established before other work can be done.
- Allow for pauses in discussions and shifts of focus; take a moment to coach coping skills. (e.g. "let's pause and take some deep breaths together").

OFFER CHOICE

- Ensure the client understands that they have the option to not answer or to not go into detail. The client may not yet have the skills to do it safely.
- Provide options for ways through which the client can provide information (e.g. interview or written questionnaires).

DON'T ASSUME

- Remember that someone may have experienced trauma without having disclosed.

SUPPORT

- Check in with the client to ensure any discussion of trauma feels safe and not overwhelming.
- Move at the client's pace; respect their desire to share details or not.
- Respond to any disclosures with belief.
- Assess current safety; develop a safety and comfort plan that recognizes and strengthens coping skills - and establishes a therapeutic agreement on how to manage extreme distress and to maximize health and well-being.

ACCEPT

- Take a non-judgmental stance that supports the client in moving from self-judgment to self-acceptance and compassion for self.

RECOGNIZE

- Be aware of possible triggers in the environment and in your interactions with the client related to: power differentials; decision-making; changes or transitions; feelings of vulnerability; and positive attention (e.g. oppositionality when therapist is seen to be exerting control; client shutting down when the therapist behaves in a nurturing way or, conversely, when client perceives cues of abandonment).
- Be sensitive to the client's discomfort in talking about difficult topics. Ask for their input on how to make this more comfortable.
- Be vigilant for the client's fight, flight and freeze responses.

SAFE COPING

- Help the client to recognize triggers in their current life and teach safe coping strategies when faced with these triggers.

PREPARE

- Orient the client to the discussion of trauma by explaining that many clients who have mental health and/or substance use difficulties have also experienced trauma, and that there can be many different kinds of impacts on their lives.
- Explain that the goal of asking questions is to understand what these impacts could be for the client.
- Explain the need to report specific disclosures (e.g. current child abuse, imminent danger to self or others) as a way of protecting the client and helping them through a difficult time; acknowledge the possibility that this will be experienced as betrayal and further trauma.

VALIDATE

- Use validation to communicate that the client's emotions and behaviours make sense given what they have gone through.

PERSEVERE

- Understand that behaviours that develop in response to trauma can be strongly entrenched, particularly when traumatic events were ongoing, frequent and started at an early age.
- Treatment can be a long-term process; whether providing long-term or brief support ensure the client experiences success by working on achievable goals.

CLINICIANS AND TRAUMA-INFORMED PRACTICE

TRANSFERENCE & COUNTERTRANSFERENCE

TRANSFERENCE

- Transference refers to feelings and experiences from the past that clients transfer or project onto the clinician in the current therapeutic relationship.
- Themes of power and control are common transference reactions.
- A common therapeutic intervention is to support clients (who are able) to reflect on and understand feelings elicited with the therapeutic relationship.

COUNTERTRANSFERENCE

- Countertransference refers to reactions and responses that a clinician can have towards a client.
- Countertransference reactions are based on the clinician's own history and personal issues; they include the clinician's response to a client's transference reactions.
- Countertransference is normal and can be a useful therapeutic tool when the clinician recognizes and questions their own thoughts and feelings; it can provide insight into the emotional content of the therapeutic relationship and the client's interpersonal dynamics beyond the therapeutic setting.

HOW TO BE AWARE OF COUNTERTRANSFERENCE

- Am I aware of my countertransference? What personal feelings are being elicited through my work generally – and with this client specifically? How are they affecting my clinical work?
- Am I feeling overwhelmed, angry, or hopeless in my work with this client?
- Am I speeding up / slowing down the therapeutic process to meet my own emotional needs?
- What is hardest and worries me most about work with clients who have lived through trauma?
- How has my clinical work changed me over time?
- What am I doing to take care of myself?

"The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet."

- Naomi Remen

TRAUMA EXPOSURE RESPONSE

("Vicarious Trauma" / "Compassion Fatigue")

TRAUMA EXPOSURE RESPONSE

Trauma exposure response is the impact on a clinician of working directly with clients who have experienced or been affected by trauma.

SIGNS OF TRAUMA EXPOSURE RESPONSE

As with a client's response to trauma, the trauma exposure response is on a continuum; clinicians may experience one or more of the following indicators to varying degrees:

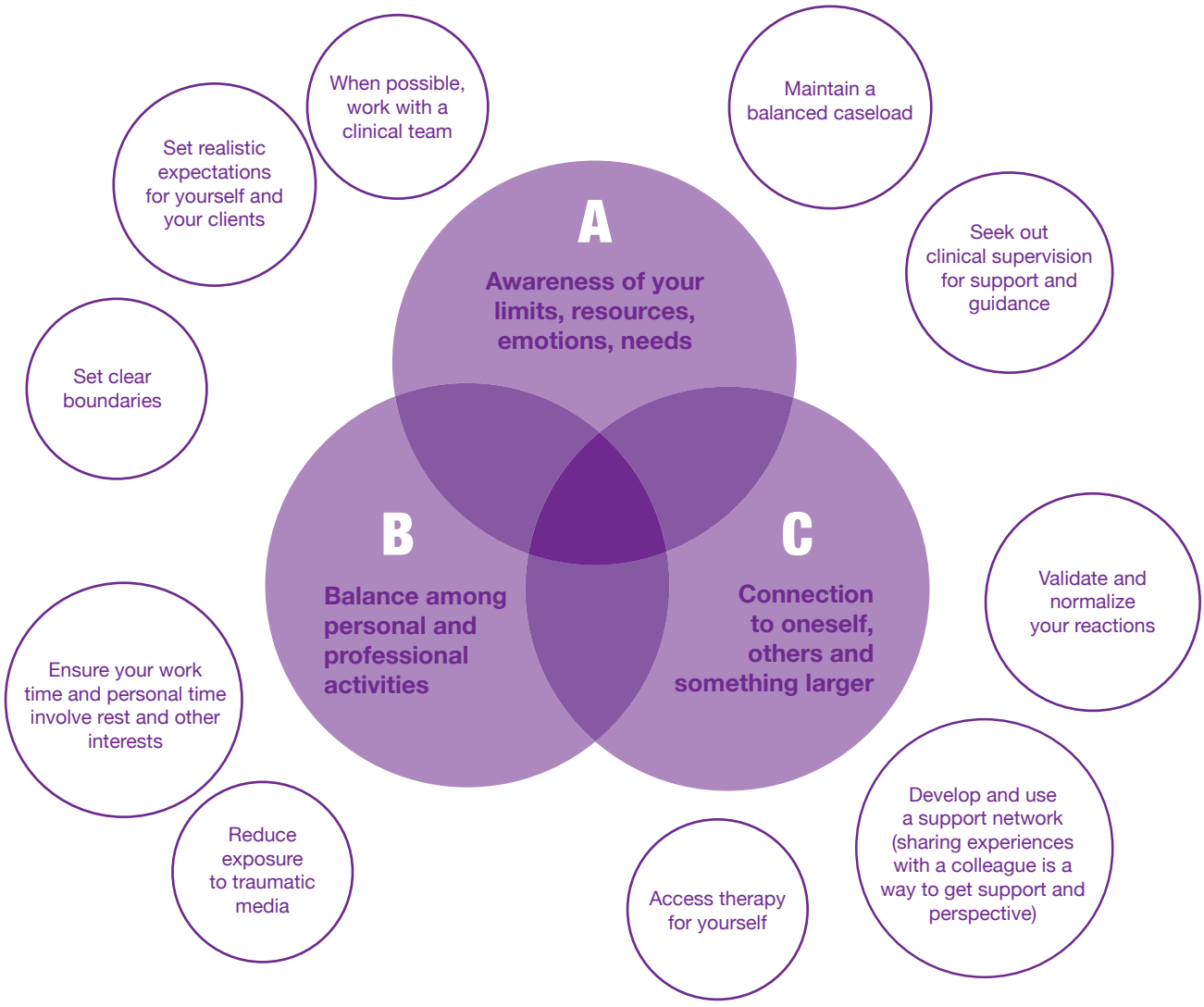
- hyposensitive to emotional material: numbed and discouraged about work with clients
- hypersensitive to emotional material: over-identified and over-involved with clients
- increased sense of personal vulnerability
- feeling isolated and guilty over emotional experience of work with clients
- deliberate avoidance of clients
- absenteeism at work

RISK AND PROTECTIVE FACTORS FOR TRAUMA EXPOSURE RESPONSE

Risk factors	Protective factors
• having a history of trauma • lack of experience • working exclusively with clients who have lived through trauma • experiencing negative clinical outcomes • not attending to personal emotional and physical health indicators	• social support in and out of work • clinical support / supervision • trauma-specific training

BUILDING CLINICIAN RESILIENCE: **The ABC Model of Clinician Self-Care**

A: *Awareness* **B:** *Balance* **C:** *Connection*



Resources: Trauma-Informed: The Trauma Toolkit, Second Edition, 2013 (Klinic Community Health Centre, Winnipeg) / Trauma Matters: Guidelines for Trauma-Informed Practices in Women's Substance Use Services, 2013 (Jean Tweed Centre For Women and Their Families, Toronto) / Trauma & Resilience: An Adolescent Provider Toolkit, 2013 / Understanding and Transforming Compassion Fatigue and Vicarious Trauma, (2013) (Francoise Mathieu) / The 12 Core Concepts: Concepts for Understanding Traumatic Stress Responses in Children and Families, 2012 (National Child Traumatic Stress Network) / Helping Traumatized Children Learn, 2009, (Massachusetts Advocates for Children, Boston) / Child Development and Trauma Guide, 2012, (Victoria State Government of Australia, Melbourne) / Trauma-Informed Care in the Prevention and Management of Aggressive Behaviour (draft), 2014 (CAMH Education Services, Toronto); Compassion Fatigue Solutions, www.compassionfatigue.ca