Fusing Trauma, Trauma-Informed Care, Resiliency and Suicide Prevention

PRESENTED BY:
Michele Calvo
Policy Associate, The New York Academy of Medicine

Laurie Montanaro, LCSW
The Bridge PROS Program/Mental Health Clinic Clinical Services Coordinator

Susan Jenkins
Executive Director, BRiDGES
Madison County Council on Alcoholism and Substance Abuse, Inc.
How to Use GoToWebinar

GoToWebinar Viewer

GoToWebinar Control panel
How to Use Gotowebinar

Your Participation

Open and hide your control panel

Submit questions and comments via the Questions panel

Note: Today’s presentation is being recorded and will be distributed at a later date.

If you have any technical questions or problems please contact:

Rebecca Abraham
RAbraham@NYAM.org
• Brief introduction to NYAM & APP
• Part 1: What is trauma?
• Part 2: Building Resiliency
• Part 3: The key principles of trauma-informed care
• Part 4: Examples from the field
• Q&A, Discussion
About The New York Academy of Medicine

Current Priorities:

• Healthy Aging
• Disease Prevention
• Eliminating Health Disparities.
About The Advancing Prevention Project

Supports the implementation of Prevention Agenda plans in the priority areas of:

• Prevent Chronic Disease
• Promote Mental Health/Prevent Substance Abuse

www.advancingpreventionproject.org
About The Advancing Prevention Project

Our Staff

Michele Calvo
Kim Libman
Chideraa Ukeje
Rebecca Abraham

Our Content Experts

Kate Ebersole
Elizabeth Meeker

Our MH/SA Advisory Group

• NYS DOH
• NYS OASAS
• NYS OMH
• Suicide Prevention Center of NY
New York State Prevention Agenda
Priorities Selected by Counties, 2013

Priority Areas (# Selected by Counties)
- Chronic Disease (n=57)
- Mental Health and Substance Abuse (n=29)
- Women, Infants, Children (n=16)
- Environment (n=9)
- HIV, STD, Vaccines & HAI (n=3)
Part 1:
An Introduction to Trauma
Trauma: The Three E’s*

• **Event** – exposure to an event or series of events that threatens the well-being of an individual or group

• **Experience** - respond to the event with intense fear, helplessness and/or horror

• **Effect** - shakes our basic beliefs about safety, predictability & trust

*Indicates slide was developed by Dr. Elizabeth Meeker, PsyD, CCSI (Coordinated Care Services, Inc.)
Types of Traumatic Events

• Can be **acute** or **chronic**
• Can occur to an **individual**, as a **family**, in a system, or as a **community**
• Can be **complex**
Types of Traumatic Events

- Sexual Abuse or Assault
- Physical Abuse or Assault
- Emotional Abuse or Psychological Maltreatment
- Neglect
- Victim or Witness to Extreme Personal or Interpersonal Violence
- Serious Accident, Illness, or Medical Procedure
- School Violence
- Bullying

- Natural or Manmade Disasters
- Forced Displacement
- War, Terrorism, or Political Violence
- Military Trauma
- Traumatic Grief or Separation
- Victim or Witness to Community Violence
- Historical Trauma
- System-Induced Trauma and Re-traumatization

*Bolded events are well-identified risk factors for suicide*
A traumatic stress response occurs when our ability to respond to the threat is overwhelmed.
Impact on My World View*

- I am not safe
- I cannot trust others
- I cannot trust myself
- I cannot depend upon others
- I am not worthy of care
- I am powerless
- I deserve the bad things that happen to me
- It’s my fault
Complex Trauma & Toxic Stress*
Adverse Childhood Experiences (ACES)

Adverse Childhood Experiences (ACES)

• Most studies actually show “graded” relationships or “dose-related”

• Disease risk not fully explained by risk behaviors

Number of Adverse Childhood Experiences and Lifetime History of Attempted Suicide

What’s the Take Home Message?*

- The majority of adults and children in psychiatric treatment setting have trauma histories
- Many people with substance use disorders have traumatic stress symptoms that interfere with achieving or maintaining sobriety
- The majority of adults and children in the prison or juvenile justice system have trauma histories
The Impact of Trauma On Survivors*

“Complex trauma outcomes are most likely to develop and persist if an infant or child is exposed to danger that is unpredictable and uncontrollable because the child’s body must allocate resources that are normally dedicated to growth and development instead to survival.”³
Stress Response*

Positive
- Brief increase in heart rate
- Mild elevation in stress hormones

Tolerable
- Serious, temporary stress response
- Buffered by supportive relationships

Toxic
- Prolonged activation of stress response
- Absence of positive relationships
FIGHT*

FREEZE

FLIGHT
Individual reacts as though a “there and then” experience is happening “here and now”*
Common Post-Traumatic Triggers*

- Therapy & therapists
- Being asked questions
- Self-disclosure
- Being put on the spot
- Being center of attention
- Loud noises
- Authority figures
- Being told “No”
- Males/females
- Criticism, feedback
- Home/family
- Eye Contact

- Recall of traumatic event
- Anniversaries
- Not allowed to speak
- Being ignored
- Emotions, vulnerability
- Unfamiliar stimuli
- Performance demands
- Having to say “Yes”
- Night time, sleep
- Confrontation
- Intimacy
- Commitment
Survival Response*

- **Fight: Physical Arousal**
  - Individual struggles to regain or hold on to power, especially when feeling coerced
  - Mislabeled as: Non-compliant or combative

- **Flight: Withdrawal and Escape**
  - Individual disengages or runs away and “check outs” emotionally
  - Mislabeled as: Uncooperative or resistant

- **Freeze: Stilling and Constricting**
  - Individual gives in to those in positions or power, does not or is unable to speak up
  - Mislabeled as: Passive or unmotivated

**Our interpretation guides our intervention**
Current problematic behaviors and symptoms may have originated as legitimate and even courageous attempts to cope with or defend against trauma.*
Part 2:
Building Resiliency
Agenda

Resilience Trumps ACEs*

• ACEs are **NOT** a life sentence and they are **NOT** set in stone
“I believe each one of us has the capacity to become resilient. But our parents, siblings, extended family and community can either give us resilience or reduce our resilience. I also believe that resilience is like a muscle. You can strengthen your resilience, just as you strengthen a muscle.”

- Tina Marie Hahn, MD
Resilience*

I Have
• External supports and resources

I Am
• Internal, personal strengths

I Can
• Social and interpersonal skills

ADVANCING PREVENTION PROJECT

NYS HEALTH FOUNDATION
Improving the state of New York’s health

The New York Academy of Medicine
At the heart of urban health since 1847
## Examples of Resiliency

<table>
<thead>
<tr>
<th>Ways to build resilience</th>
<th>Examples</th>
<th>Five Essential Factors in the Protective Factors Framework</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help build connections with others</td>
<td>Participation in civic groups or mutual support groups</td>
<td>Parental resilience</td>
<td>Peer support, transportation, access to child care</td>
</tr>
<tr>
<td>Encourage self-care</td>
<td>Exercise or relaxation techniques</td>
<td>Social connections</td>
<td>Connecting to networks of mutual support</td>
</tr>
<tr>
<td>Promote mindfulness and emotional regulation</td>
<td>Meditation</td>
<td>Knowledge of parenting and child development.</td>
<td>Promoting “warm but firm” strategies</td>
</tr>
<tr>
<td>Encourage goal-setting</td>
<td>Practicing daily SMART (specific, measurable, achievable, realistic, time-bounded) goals</td>
<td>Concrete support in times of need</td>
<td>Linking to support services like a food pantry during a crisis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Child social and emotional competence</td>
<td>Early identification and assistance, like Head Start</td>
</tr>
</tbody>
</table>
Resiliency

<table>
<thead>
<tr>
<th>Signs of This Type of Resilience</th>
<th>Vulnerability Factors Inhibiting Resilience</th>
<th>Protective Factors Enhancing Resilience</th>
<th>Facilitators of Resilience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connectedness</td>
<td>Lack of support services</td>
<td>Access to support services</td>
<td>Community leaders</td>
</tr>
<tr>
<td>Commitment to community</td>
<td>Social discrimination</td>
<td>Community networking</td>
<td>Faith-based organizations</td>
</tr>
<tr>
<td>Shared values</td>
<td>Cultural discrimination</td>
<td>Strong cultural identity</td>
<td>Volunteers</td>
</tr>
<tr>
<td>Structure, roles, and responsibilities exist throughout community</td>
<td>Norms tolerating violence</td>
<td>Strong social support systems</td>
<td>Nonprofit organizations</td>
</tr>
<tr>
<td>Supportive</td>
<td>Deviant peer group</td>
<td>Norms against violence</td>
<td>Churches/houses of worship</td>
</tr>
<tr>
<td>Good communication</td>
<td>Low socioeconomic status</td>
<td>Identification as a community</td>
<td>Support services staff</td>
</tr>
<tr>
<td>Resource sharing</td>
<td>Crime rate</td>
<td>Cohesive community leadership</td>
<td>Teachers</td>
</tr>
<tr>
<td>Volunteerism</td>
<td>Community disorganization</td>
<td></td>
<td>Youth groups</td>
</tr>
<tr>
<td>Responsive organizations</td>
<td>Civil rivalry</td>
<td></td>
<td>Boy/Girl Scouts</td>
</tr>
<tr>
<td>Strong schools</td>
<td></td>
<td></td>
<td>Planned social networking events</td>
</tr>
</tbody>
</table>

SAMHSA
Part 3:
The Key Principles of Trauma-Informed Care
“Systems serve survivors of childhood trauma without treating them for the consequences of that trauma; more significant, systems service individuals without even being aware of the trauma that occurred.”
Changes in Understanding

- Trauma-informed vs. trauma-specific
- Trauma-informed services:
  - Incorporate knowledge about trauma—prevalence, impact, and recovery—in all aspects of service delivery and practice
  - Are hospitable and engaging for survivors
  - Minimize re-victimization: “do no harm”
  - Facilitate healing, recovery, empowerment
  - Emphasize collaboration throughout the system\(^9\)
NOTE: Trauma Informed Care is NOT a program – It is an ongoing process that is unique to the strengths and needs of each organization and community
## Trauma-Informed Care*

<table>
<thead>
<tr>
<th>The Paradigm Shift</th>
<th>Traditional</th>
<th>Trauma Informed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding Trauma</td>
<td>DSM Criteria for PTSD</td>
<td>Defining &amp; organizing experience, core of individual’s identity</td>
</tr>
<tr>
<td>Understanding the Survivor</td>
<td>Symptom based</td>
<td>Based on individual within the context of their experience</td>
</tr>
</tbody>
</table>

*ADVANCING PREVENTION PROJECT*
<table>
<thead>
<tr>
<th>The Paradigm Shift</th>
<th>Traditional</th>
<th>Trauma Informed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding Services</td>
<td>Time limited, focus on stabilization &amp; symptom reduction</td>
<td>Strength based, focus on mastery of skills to cope in healthy way</td>
</tr>
<tr>
<td>Understanding Service Relationship</td>
<td>Survivor is passive recipient of services, hierarchical</td>
<td>Open &amp; genuine collaboration between provider &amp; survivor</td>
</tr>
</tbody>
</table>
Creating a Culture Shift*

- Involves all aspects of program activities, setting, relationships, and atmosphere (more than implementing new services)
- Involves all groups: administrators, supervisors, direct service staff, support staff, and consumers/families (more than service providers)
- Involves making trauma-informed change into a new routine, a new way of thinking and acting (more than new information)
Core Values of Trauma-Informed Care*

- **Safety:** Ensuring physical and emotional safety
- **Trustworthiness:** Maximizing trustworthiness, making tasks clear, and maintaining appropriate boundaries
- **Choice:** Prioritizing developmentally appropriate choice and control
- **Collaboration:** Maximizing collaboration and sharing of power
- **Restore power:** Prioritizing empowerment and skill-building^9

---

ADVANCING PREVENTION PROJECT
Create Safety & Trust

- Be warm, respectful, and non-threatening
- Listen openly and do not judge
- Ask-Provide-Ask
- Clarify the process
  - Carefully introduce self, process, and possible options
  - Do not assume that individual has been given accurate information
  - Do not assume individual knows what is expected of them and what they should expect
  - You may need to share information in multiple ways (verbal, written) and multiple times
- Gather information in a private area
- Follow through on commitments
Build Collaboration, Choice, & Empowerment

• Balance the need to obtain information or complete a specific task with individual and family identified needs
• Individuals/families often need help negotiating with other “systems”
  • Responding to concerns provide an opportunity to demonstrate commitment and potential capacity for help
• Identify & problem-solve barriers
• Maximize choice and control (i.e., time to meet, location)
Think about:

- What are you currently doing in your daily work that reflects each value?
- What could you do differently?
- What might be the obstacles you would encounter?
- How could you address those potential barriers?
Recap – Connections Between Trauma & Suicide

People often
• aren’t asked
• don’t tell
• feel they have secret and experience shame
• experience failure and sense of unworthiness
• feel isolated and alone
• feel helpless and hopeless
• feel detached
• have impaired judgment and self-regulation

Risk factors & At-Risk Groups
• Many types of trauma = strong risk factor for suicide
• Suicide attempt can be traumatic experience – both witnessing and experiencing
• Overlap in disparities
Recap- Connections Between Trauma-Informed Care & Suicide Prevention

• Importance of language
• Avoid re-traumatization
• Promote protective factors for suicide prevention
• Universal precautions
• Open the door for conversation
• Break the stigma
### Recap: Risk & Protective factors for suicide

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Protective Factors (not exclusive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure to traumatic events</td>
<td>Easy access to a variety of clinical interventions and support for <strong>help-seeking</strong></td>
</tr>
<tr>
<td>Some major physical illnesses</td>
<td><strong>Strong connections</strong> to family and community (e.g., adult mentors, service providers)</td>
</tr>
<tr>
<td>Job or financial loss</td>
<td>Support through ongoing medical and mental health care <strong>relationships</strong></td>
</tr>
<tr>
<td>Relational or social loss</td>
<td>Strong social support networks</td>
</tr>
<tr>
<td>Lack of social support and sense of isolation</td>
<td>Skills in problem solving, conflict resolution and nonviolent handling of disputes (aka <strong>resiliency</strong>)</td>
</tr>
<tr>
<td>A sense of hopelessness</td>
<td></td>
</tr>
<tr>
<td>Exposure to a range of suicidal behaviors</td>
<td></td>
</tr>
</tbody>
</table>
References

8. Harris, R. & Fallot, M. Using Trauma Theory to Design Service Systems: New Directions for Mental Health Services, Number 89. 2001
Part 4: Examples from the field
Examples From the Field

Laurie Montanaro, LCSW
The Bridge PROS Program/Mental Health Clinic Clinical Services Coordinator

lmontanaro@thebridgeny.org
Examples From the Field

**Susan Jenkins**, M.S., CEAP, CPP-G
Executive Director,
BRiDGES Employee Assistance Program
Madison County Council on Alcoholism and Substance Abuse, Inc.
Coordinator,
Suicide Prevention Coalition for Madison County

sjenkins@bridges-mccasa.org
Questions? Comments?
Type them here ➔
or raise your hand
New Resource

Trauma-Informed & Resilient Communities: A Primer for Public Health Practitioners

Thank you!

www.AdvancingPreventionProject.org