Recognizing Trauma in Mental Health: Trauma-Informed Responses with Youth and People with Psychosis

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Trauma Talks 2016
Speaking the Unspoken: Advocacy for Trauma-Informed Care

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Acknowledgements and Special Thanks

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Objectives

At the end of this workshop, you will be able to:

- Recognize the features of PTSD and Complex PTSD
- Describe potentially traumatic events
- Delineate the symptoms of trauma and how behaviours are reflected in different populations (children / youth and people with psychosis)
- Describe a stage-oriented approach to trauma-informed care
- Apply the principles discussed to your own practice
Experiences That Can Lead to Trauma

- Childhood neglect, physical, sexual and emotional abuse
- Multiple losses; repeated abandonment; sudden and traumatic loss
- War-related phenomena and combat; genocide
- Sexual assault or rape
- Physical assault and threats
- Natural disasters (earthquake, fire, MVA)
- Living in extreme poverty
- Witnessing violence
- Experience of psychosis may be a source of trauma for some
- Cultural and intergenerational trauma

Camh
Post Traumatic Stress Disorder (PTSD, DSM V)

- Experience or witness
- Learning about a traumatic event to a close family member or friend
- Repeated or extreme exposure to aversive details of the traumatic events
- Clinically significant distress or impairment
Symptoms of PTSD

A) RE-EXPERIENCING
B) AVOIDANCE
C) NEGATIVE ALTERATIONS IN COGNITIONS & MOOD
D) ALTERATIONS IN AROUSAL
Complex PTSD (Herman, 1992)

- Abuse is of an interpersonal nature
- Prolonged, repeated - lasts over months to years
- Takes the form of being under perpetrator’s control - unable to get away

- Emotional/physical captivity:
  - long term childhood physical or sexual abuse
  - emotional abuse
  - domestic battering
  - hostage
  - prisoner of war
  - concentration camp survivor
  - religious cult
  - sexual exploitation: prostitution brothels; organized child exploitation rings
  - torture - physical, psychological
Symptoms of Complex PTSD
(Herman, 1992)

ALTERATIONS IN:

- Ability to control emotions
- Consciousness
- Self-perception
- Perception of perpetrator
- Relations with others
- Systems of meaning
Danger/Threat Response

- in response to danger/threat, the mind and body protects us by preparing us to fight, flee, or freeze
“Amygdala goes off too frequently”

“Brain becomes conditioned to treat all potential threats as actual threats”
Therapeutic Considerations: Trauma-Related Work with Children/Youth
Developmental Trauma

is trauma that occurs during the formative years of childhood and youth and that impacts normative development.
• Most common childhood traumas (psychological maltreatment, neglect, separation from parent) are not always thought of as trauma

• Children with trauma-related behaviours are more likely to receive diagnoses of:
  • Separation Anxiety
  • Oppositional Defiant Disorder
  • Attention Deficit – Hyperactivity Disorder
Typical developmental processes are interrupted:

- Physical health
- Attachment
- Emotion and behaviour regulation
- Intrapersonal growth
- Interpersonal growth
Therapeutic Considerations: Trauma-related Work with Individuals with Psychosis
Engagement, Engagement, Engagement…..

- Multiple personal setbacks and stressors
- Positive Symptoms (ex. voices, paranoia, delusions)
- Negative symptoms (anhedonia and apathy)
- Co-occurring substance use
- Mistrust
- Stigma
- Impact: missing appointments, premature termination

Recommendation:
- Pacing, extra time to develop trust
- Flexibility with appointments, scheduling and termination “criteria”
Symptoms of Psychosis
(Fife, 2009)

- Complicate PTSD
- Consider the fright and confusion of experiencing symptoms of psychosis
- Impact ability “to trust one’s own senses and thoughts”

Recommendations:
- Trauma history - is there a personal history of being harmed, bullied?
- This may take time to unravel within the therapeutic relationship
- Thought content / delusion content may reflect themes of fear (i.e: feeling unsafe, feeling people are “out to get me”)

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Cognitive Impairments
(Fife, 2009)

- Problems with attention, memory, abstract reasoning and concentration
- Trouble generalizing and applying skills into every-day life

Recommendations:
- Present information slowly; repeat often
- Model skills
- Involve supports
Telling the story

Stage Oriented Treatment for Adult Survivors of Child Abuse (Chu, 1998)

- Late Stage Treatment: Reconnection
- Middle Stage Treatment: Telling the story
- Early Stage Treatment: Self-Care/Symptom Control/Acknowledgement/Functioning/Expression/Relationships
Trauma-Informed Organizational Practices

1. Understanding that trauma is a central issue
2. Making a commitment to trauma-informed practices across the organization
3. Learning from people with lived experience
4. Training
5. Developing staff competencies
6. Clinical supervision and consultation
7. Assessing the current state
8. Leadership and champions
9. Attending to safety in the physical setting

Trauma Matters: Guidelines for Trauma-Informed Practices in Women’s Substance Use Services, March 2013, pages 109 – 111)
A Staged Approach to TIC in Our CAMH Settings

Our Story

- High Prevalence of concurrent trauma issues and histories within our hospitalized and specialty populations (child/youth and psychosis)
- Raising Awareness: prevalence, impact, knowledge into practice
- Education – local units/teams and organizationally
- Advocacy
Trauma-Informed Practice Considerations
(adapted from: Jean Tweed Centre. *Trauma Matters: Guidelines for Trauma-Informed Practices in Women’s Substance Use Services*. March 2013)

<table>
<thead>
<tr>
<th>ACKNOWLEDGE</th>
<th>SAFETY</th>
<th>TRUSTWORTHINESS</th>
<th>CHOICE AND CONTROL</th>
<th>COLLABORATIVE APPROACH</th>
<th>STRENGTHS BASED</th>
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<tbody>
<tr>
<td>prevalence</td>
<td>responses that could be perceived as dangerous (cutting, burning, isolation, withdrawal) may actually feel safer to the person because of their trauma experiences- framed as adaptive ways to survive</td>
<td>expect that it will be hard for people to build trust</td>
<td>remain flexible and look at range of options</td>
<td>strive to understand the whole person</td>
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<td>normal reactions to abnormal stress events</td>
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<td>will take time to build trusting therapeutic relationships</td>
<td>client centered care – client should be centre of own treatment</td>
<td>ask for client’s own views and input</td>
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<td>psychosis can itself be traumatic</td>
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<td>vigilance and suspiciousness should be expected (as a coping mechanism)</td>
<td>provide as much choice as possible</td>
<td>collaboration equalizes power imbalances and establishes trust</td>
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<td>trauma interferes with normal development</td>
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<td>Re: treatment and care planning</td>
<td>demonstrate empathy and respect</td>
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<td>the trauma endured will impact the person’s experience of the world</td>
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<td>respectful of boundaries</td>
<td>non-judgemental approach</td>
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<td>trauma is pervasive</td>
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<td>asking permission</td>
<td>transparency</td>
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<td>be self aware Eg: body language and facial expression</td>
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<td>requires being a genuine, active listener</td>
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<td>psychoeducation regarding the psychosis empowers recovery</td>
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Physical, emotional and cultural safety in the environment

Safety plan

Consider safe /alternate coping strategies (eg: grounding)

Be mindful of possible triggers (Eg: fire alarm)

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Kamil: Background

- 45 year old male who migrated to Canada from Poland at age 12
- Diagnosed with schizophrenia at age 20
- Lives in boarding home, falling behind on his rent, limited supports
- Frequent Auditory Hallucinations/Voices telling Kamil he is “cursed” and “doomed to go to Hell”
- Experiences paranoia; has a delusional belief that an “evil spirit” is after him to bring him to Hell “to get what he deserves for being such a dirty boy”
- Kamil was recently discharged from hospital following a brief stay after threatening to assault boarding home staff member who entered his room in evening unannounced
- Today is Kamil’s first visit with his therapist, since being discharged from hospital
- Kamil has previously shared with therapist that his maternal uncle terrified Kamil at night when Kamil and his family stayed with uncle during first 6 months after they moved to Canada
- Kamil is guarded about further details involving the terror he experienced in response to his uncle during this period
Kamil: Scenario 1
Kamil: Scenario 2
Jack: Background

- 17 years old with diagnoses of attention deficit hyperactivity disorder, generalized anxiety disorder; has developed problematic use of cannabis and problematic gaming on League of Legends

- Lives at home with mother and brother; lived through “neglectful” parenting and physical abuse an injury from step-father; has witnessed violence against his mother

- Now enrolled in a day treatment program and participates in individual therapy
Jack: Scenario 1
Jack: Scenario 2
References


- Haskell, L. (2012). A Developmental Understanding of Complex Trauma. In N. Poole & L. Greaves (Eds.), *Becoming Trauma Informed*. Toronto: CAMH.


Thank you