



Phase 3 Implementation: Understanding Trauma and Person Centered Care

Presented by:

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F699: Trauma Informed Care Behavioral Health Federal Regulations

The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.

F742: Behavioral Health Federal Regulations

(b) Based on the comprehensive assessment of a resident, the facility must ensure that-

- A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, **or who has a history or trauma and/post-traumatic stress disorder**, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being.

Prevalence of Trauma Exposure

- **70 to 90%** of adults (65+) are exposed to at least one potentially traumatic event
- Gender differences- **70%** men, **40%** women
- Life time exposure to traumatic events for veterans reached **85%**

Trauma Exposure for Women

- **72%** of women (70+) experienced at least one traumatic event
- **44 to 55%** of women of all ages reported exposure to at least one traumatic event

Occurrence of Trauma Reaction

Boyce & Harris (2011)

45 to 65% of adults who experienced childhood trauma did not develop stress related illness as adults

Examples of Resilience Enhancing Factors

- Low levels of family discord
- Active/engaged parenting
- Maintenance of maternal relationship
- Absence of drug or alcohol abuse among direct family members

General Guidance

All people who are exposed to trauma experience distress...

Not all residents who experience distress become traumatized.... acute or chronic

Acute vs. Chronic Trauma Symptoms

Acute (lasts weeks to months):

- Adaptive-keeps person vigilant and reactive to danger
- Resolves as safe environment established

Chronic (extended period to life long affliction):

- Maladaptive stress response to everyday events
- Alters daily patterns, maladaptive coping responses
- Persistent symptoms, flashbacks, physical and emotional symptoms...avoidance, fear, and isolation become frequent experience.

Post-Traumatic Stress Disorder

Prevalence of PTSD in Older Population

- **1.5 to 4%** of general population (60+)
- **8%** lifetime prevalence in general adult population
- Those with military service approach **17%**
- Subclinical estimate for all adults is **7 to 15%**

Reasons PTSD Symptoms Change With Age

- Changes in role
- Functional loss
- Cognitive decline (emotional regulation)
- Environmental changes (stress/re-traumatization)
- Failure of existing coping strategies

PTSD & Medical Problems

- More exposure to trauma associated with more medical problems
- Increased arterial disorders
- Increased gastrointestinal complaints
- Increased dermatological problems
- Increased musculoskeletal problems

PTSD & Cognitive Problems

- Veterans with dementia exhibit more PTSD symptoms
- A dx of PTSD doubles risk of developing dementia

PTSD & Psychiatric Problems

- Associated with poor psychosocial functioning
- Higher rates of mental health problems (depression, anxiety, and substance use)

Late-Onset Stress Symptomology (LOSS)

- Increased thoughts and reminiscences about war time experience
- Occurs in context of losses associated with aging (retirement, loss of loved ones, increased health problems, etc.)

Neurological/Physiological/Psychological Disorder

A Stress Reaction Unbound to Time & Circumstances:

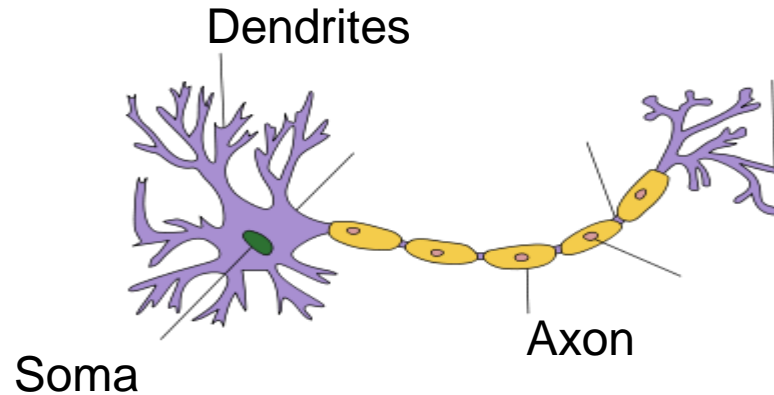
- Initially a self preserving response initiated by instinctive/reactive part of our brain, but person is unable to restore safety or adapt
- Stress Hormones Continue to Surge...Conditioning
- Neurological Changes..Hypersensitive/Reactive..a normal day can be experienced physiologically as a struggle between life and death (lower brain function dominates)
- Psychologically an altered experience of self and world, dominated by threat, avoidance, and escape

Practical Definition of PTSD

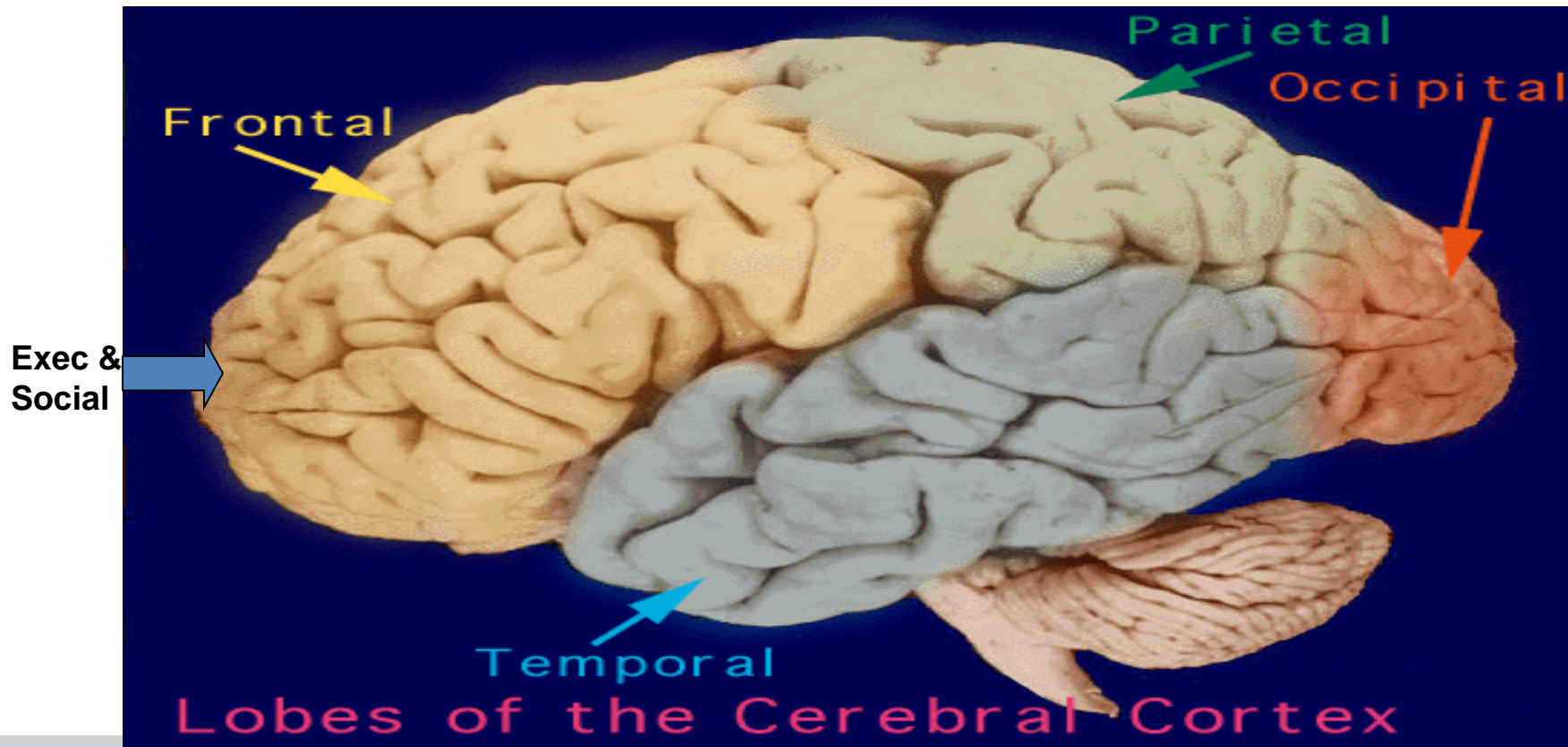
- Prolonged emotional, cognitive, and behavioral dysfunction due to having experienced an extreme stressor or stressors.
- Differs from common stress experiences in three major ways.
 1. Duration of distress.
 2. Pervasiveness of impact on one's overall functioning
 3. The alteration of one's self-view.

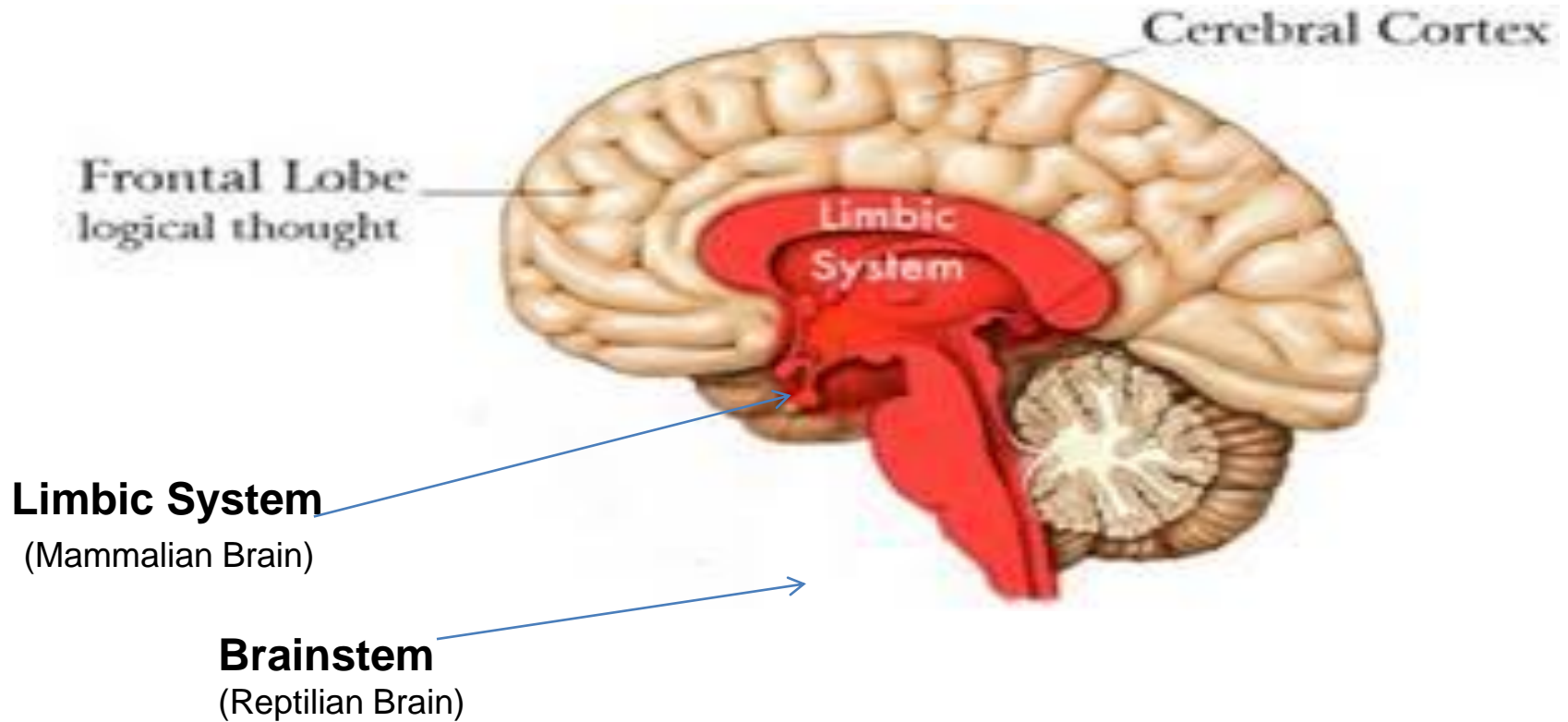
It All Starts Here

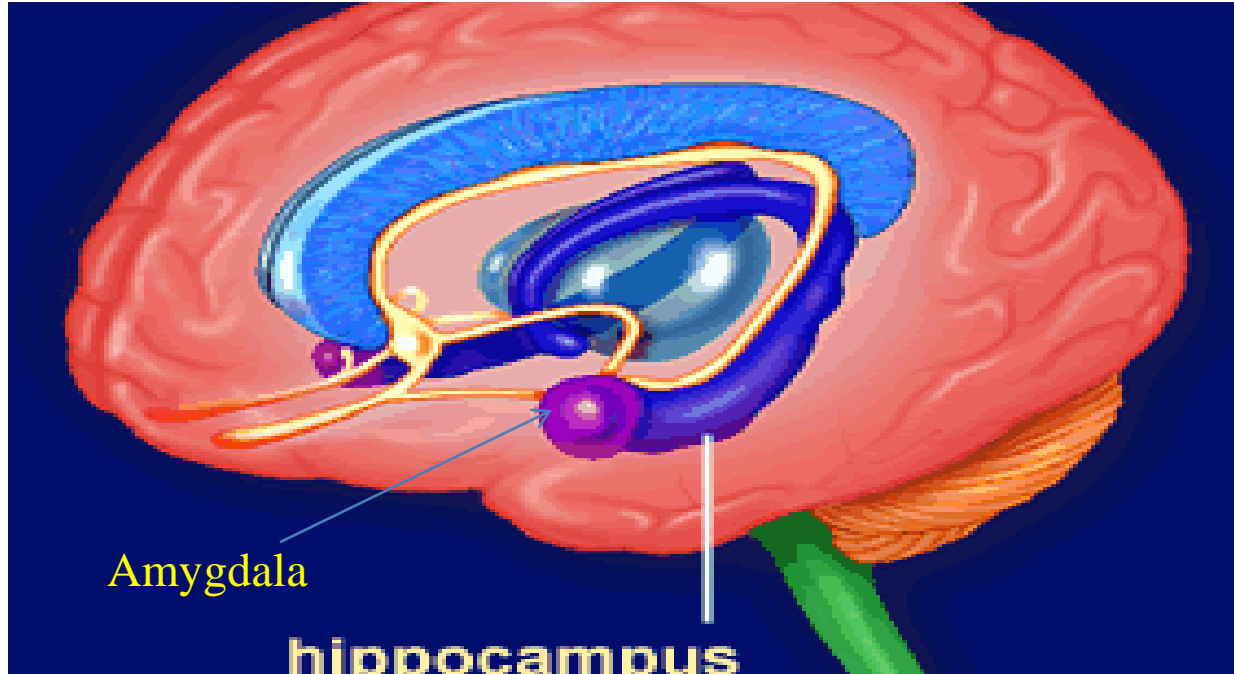
Structure of a neuron



Evolved Brain







Brain Functions

Takes external stimuli and,
as a result of our brain similarities,
creates a shared
Reality

Central Consideration

When our brain is altered so is our
experience in the world
&
Also our abilities to
respond

“Our Brain is The Self”

Physiological Factors

- Sympathetic vs. Parasympathetic
- Adrenaline (stays in system 12 to 20 min.)
- Loss of Executive Function

Executive Function

- Inability to assess consequences
- Disinhibition
- Not contextually aware
- Inability to switch modes (concrete thinking)

Mental Factors

- Past Experience
- Belief System
- Problem Solving Skills

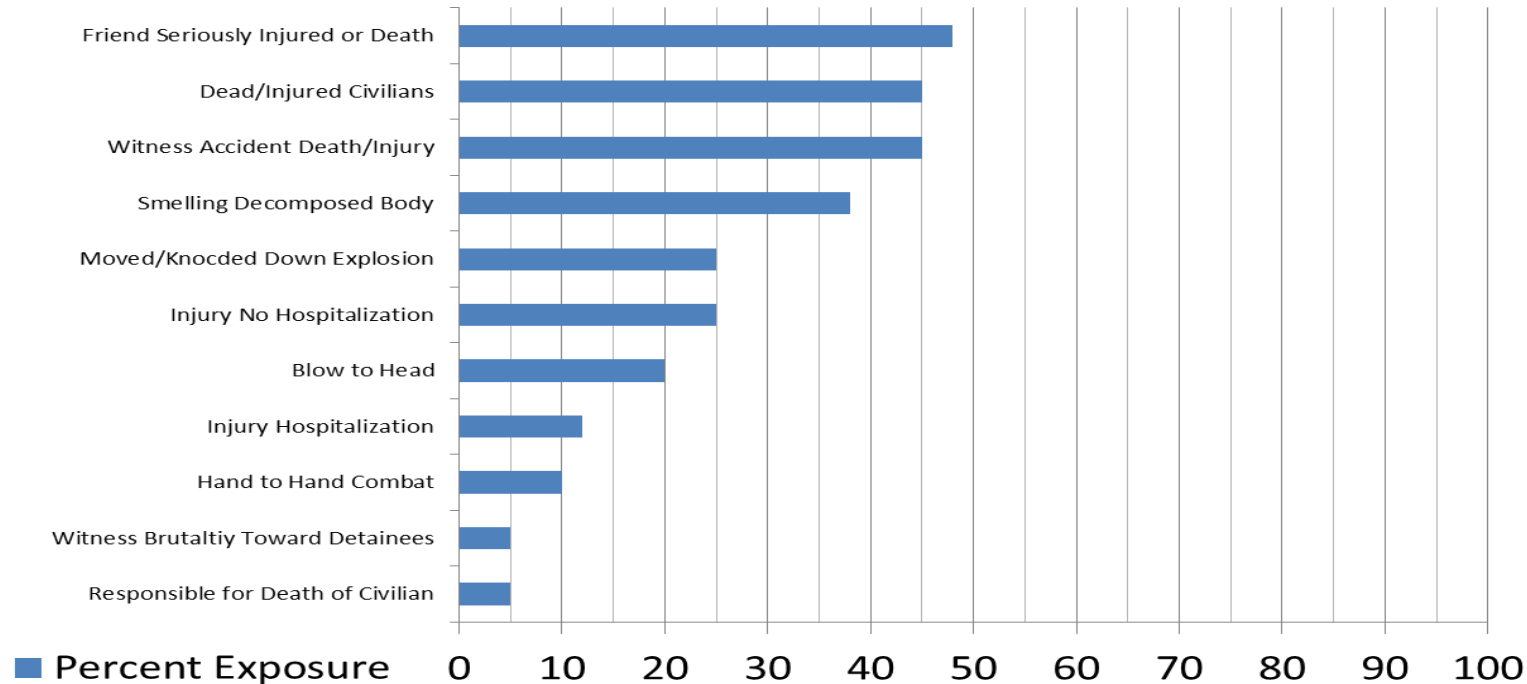
Posttraumatic Stress Disorder – DSM 5

1. Experience of a traumatic event
2. Traumatic event is persistently re-experienced (e.g. nightmares and flashbacks, dissociation).
3. Persistent avoidance of stimuli associated with the trauma, e.g. memories, or actual trauma stimuli.
4. Negative alterations in cognition and mood.
5. Persistent symptoms of increased arousal.
6. Duration of distress for more than one month.
7. The disturbance causes clinically significant distress or impairment of social, occupational, or other important areas of functioning
8. Above not due to medication or medical condition.

Stressors Leading to PTSD

- Warfare exposure
- Criminal assault
- Violent physical/sexual attack
- Witnessing violent attack on parents of significant others
- Witness parental suicide
- House fire
- Earthquakes, floods, tornadoes, hurricanes, tsunamis
- Child physical abuse
- Child sexual abuse
- Life threatening diagnosis
- Secondary or vicarious trauma

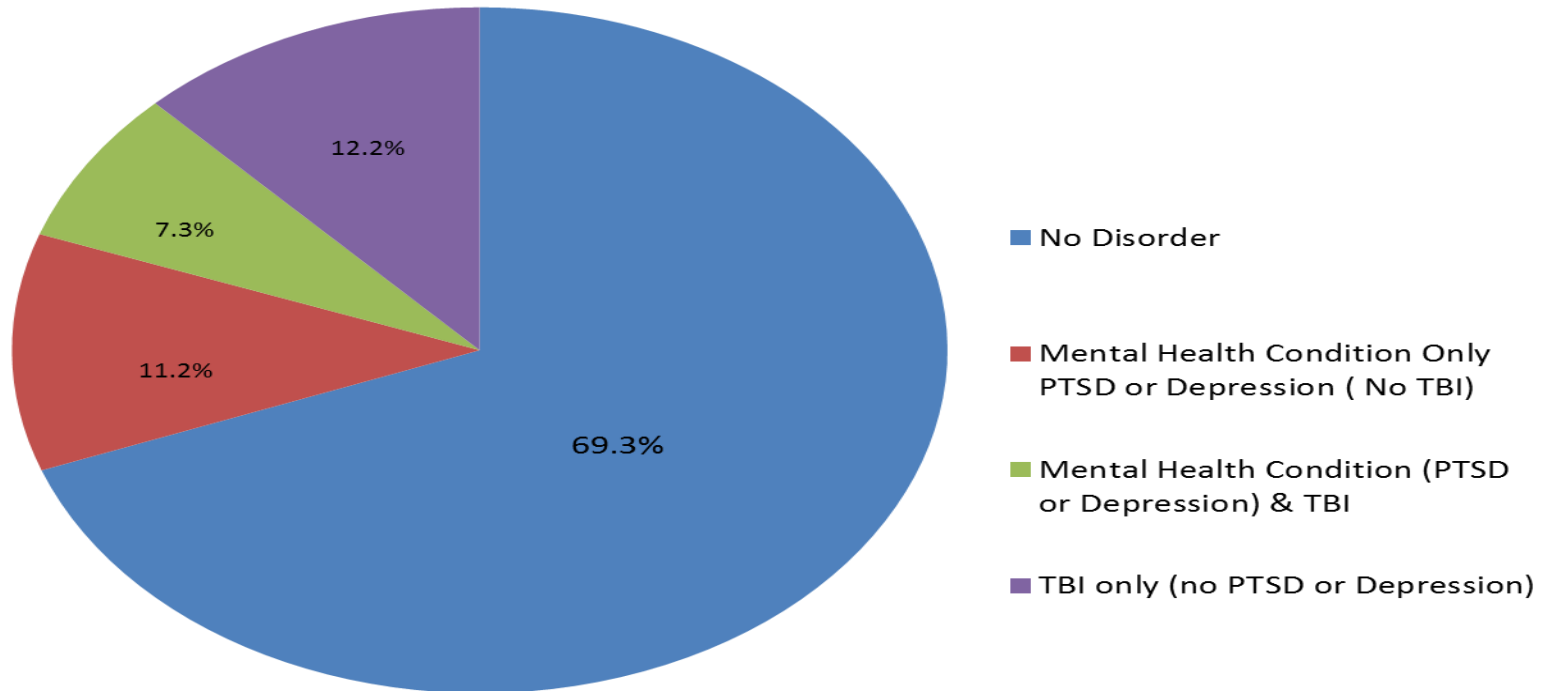
Trauma Exposures Reported by OEF/OIF* Service Members



*Operation Enduring Freedom/Operation Iraqi Freedom
Sample Size 1,965 service members

Invisible Wounds of War-2008 Rand Corporation Monograph

Probable Rates of PTSD, Depression and TBI*



***Operation Enduring Freedom/Operation Iraqi Freedom
Sample Size 1,965 service members**

Invisible Wounds of War-2008 Rand Corporation Monograph

Perspective for Therapists

“The essence of trauma is that it is overwhelming, unbelievable, and unbearable. Each patient demands that we suspend our sense of what is normal and accept that we are dealing with a dual reality: the reality of a relatively secure and predictable present that lives side by side with a ruinous, ever-present past.”

-Bessel van der Kolk (2014)

Behavioral/Psychological Component of Restoring Balance*

- Capacity to destroy each other is matched to our capacity to heal each other
- Language gives us an opportunity to communicate our experiences and shared memory
- We can regulate our own physiology
- We can change social conditions to create safe environments

* *The Body Keeps The Score (2014)*, Bessel Van Der Kolk, Penguin Books

LATEST INTERVENTIONS

- PTSD is associated with anxiety so anything that reduces anxiety and accompanying depression often helps to relieve PTSD, including the following:
- Aerobic and non-aerobic exercise reduce anxiety and depression. Exercise reduces PTSD symptoms – all ages.
- Meditation, yoga, progressive muscle relaxation procedures, etc. should all be helpful in treating PTSD.
- Medications to reduce anxiety and depression; propranolol to block adrenaline that might be the cause of the imbedding of traumatic experiences. Morning of 9-11 vs morning of 9-10.

Dept. of HHS: SAMSHA-Concept of Trauma (July 2014)

Trauma and Informed Care - The “Four R’s”:

1. Realization
2. Recognize
3. Respond
4. Resist Re-Traumatization

Realization

Realize widespread impact of trauma
and understand
potential paths of recovery

Adapted from: SAMHSA'S Trauma-Informed Approach: Key Assumptions and Principles

Recognize

Recognize signs and symptoms of trauma in residents, families, staff, and others involved with the system

Adapted from: SAMHSA'S Trauma-Informed Approach: Key Assumptions and Principles

Respond

Respond by fully integrating knowledge about trauma into policies, procedures and practice

Adapted from: SAMHSA'S Trauma-Informed Approach: Key Assumptions and Principles

Resist Re-Traumatization

Increase awareness among
staff about the importance of
actively resisting
RE-TRUAMATIZATION

Adapted from: SAMHSA'S Trauma-Informed Approach: Key Assumptions and Principles

Dept. of HHS: SAMSHA-Concept of Trauma (July 2014): Six Key Principles of Trauma In Approach

- Safety
- Collaboration/Mutuality
- Trustworthiness/
Transparency
- Empowerment, Voice, &
Choice
- Peer Support
- Cultural, Historical &
Gender Issues

Safety

Throughout the organization,
staff and residents
Feel physically and psychologically
Safe

Adapted from: SAMHSA'S Trauma-Informed Approach: Key Assumptions and Principles

Trustworthiness and Transparency

Organization's operations and decision making are conducted with transparency with the goal of building trust among residents, family members and staff.

Adapted from: SAMHSA'S Trauma-Informed Approach: Key Assumptions and Principles

Peer Support

Establish an atmosphere of support and validation of difficulties, enhancing Collaborations and promoting Recovery and maximizing a sense of Empowerment

Adapted from: SAMHSA'S Trauma-Informed Approach: Key Assumptions and Principles

Collaboration

Partnering and leveling of power
Differences between staff and residents
with emphasis that healing occurs through
Relationships

Adapted from: SAMHSA'S Trauma-Informed Approach: Key Assumptions and Principles

Empowerment

Individuals are recognized for their
Strengths and experiences and
those qualities are allowed
expression in the recovery process

Adapted from: SAMHSA'S Trauma-Informed Approach: Key Assumptions and Principles

Cultural, Historical, & Gender Issues

The organization strives to move past Cultural stereotypes and biases, especially as they relate to gender

Adapted from: SAMHSA'S Trauma-Informed Approach: Key Assumptions and Principles

Post-Traumatic Reaction

Goal is establishing an atmosphere
of calm and safety and
avoid escalation of
PTSD Reaction

Summary

- PTSD has a pervasive impact across many domains
- PTSD reactions can persist for many years
- Re-exposure to trauma stimuli is helpful in overcoming the effects of PTSD
- The impact of trauma can spread to others and this effect can be reliably measured

Essential Strategies

- Early Identification/Screening
- Quality Medical Management
- Optimal Interpersonal Management
- Proactive Environmental Accommodations

Brief Trauma Questionnaire

- 8 questions related to life threat or serious injury for events
- 2 questions related to witnessing trauma

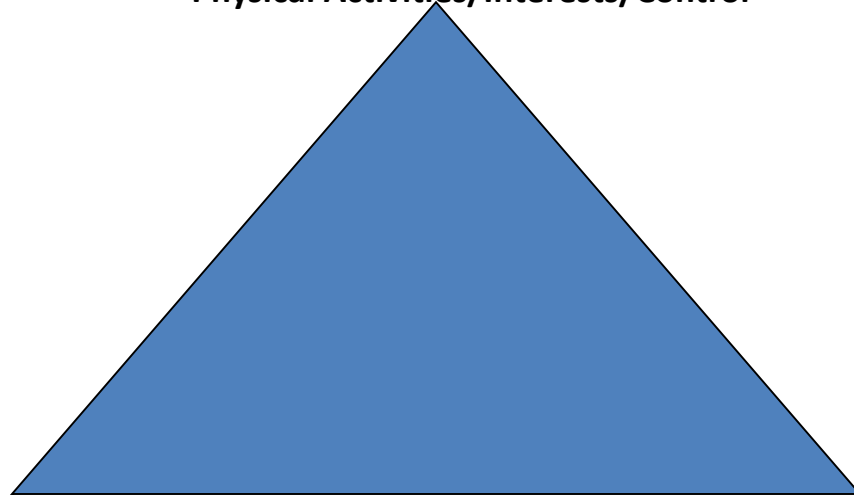
www.ptsd.va.gov

**What is the most powerful
psychological intervention ?**

Maintaining Respect & Dignity!

Trinity

Behavior
Physical Activities/Interests/Control



Thought

Feelings

Increasing Situational Awareness and Coping Statements

Meditation/Calming Activities

Starting with the Resident

- Early identification of residents' needs ...direct services quickly
- Provide feedback...Help Resident Understand Their Reactions...Reassurance.. “Not going Crazy”
- Offer Respect and Validation for Their Concerns...and Then Choose Your Chance to Offer Suggestions
- When a Resident Talks... **listen, listen, listen..!**

Minimizing Triggers

- Maintain supportive, non-critical approach
- Tone of voice and body language...eye contact
- Speak calmly & directly to resident
- Your reactions and clinical management should be resident focused

A Moment of Thoughtfulness

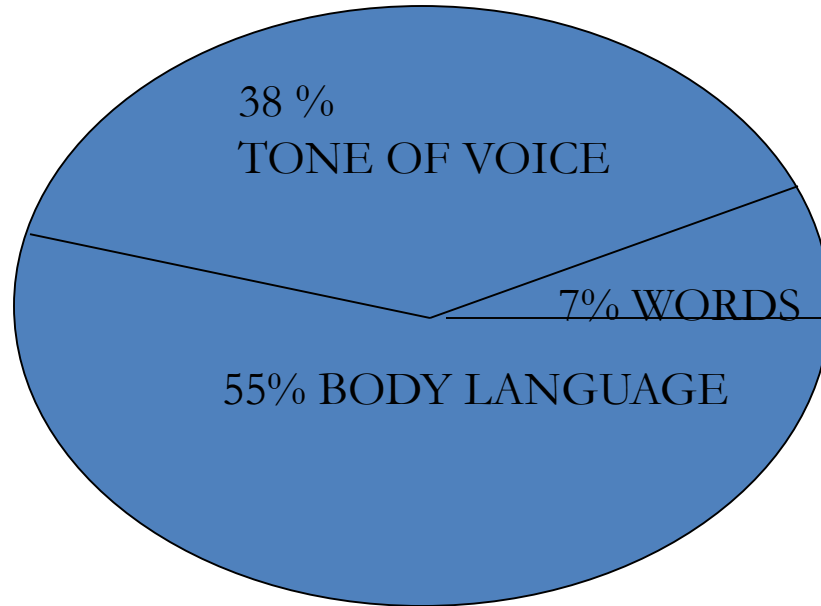
Big actions are not as polished as...

Small actions

Small actions are not as polished as

Stillness

Three Ingredients of Good Communication



Behaviors & Care Area Assessments (Mood State #8 & Behaviors #9)

Care Area Assessments: Considerations

- Medication Changes
- Illness or condition
- Exacerbating Factors
- Change in Cognitive Status

Care Area Assessments for Behavior

- Behavior provoked or unprovoked
- Offensive or Defensive
- Purposeful
- Activity when behavior occurred
- Pattern (time of day)
- Others involved or targeted
- Reaction to action/event
- Startle Response

Care Area Assessments

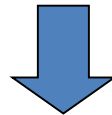
Identification/Description of Problem



Causes/contributing factors

&

Rick Factors



Care plan will or won't be initiated

Sources

1. Motta, Robert: Hofstra University “PTSD & Secondary Trauma: Practice and Research (2016), Power Point, Slides Adapted
2. “Invisible Wounds of War, (2008) Rand Corporation Monograph
3. Der Kolk, Bessel Van, “The Body Keeps The Score” Penguin Books (2014)
4. SAMHSA’S Concept of Trauma and Guidance For a Trauma-Informed Approach, SAMHSA’S Trauma and Justice Strategic Initiative (July 2014) www.samhsa.gov
5. New York State Dept. of Health Presentation; CMS Medicare Learning Network, August 11, 2015
6. www.ptsd.va.gov

Summary & Questions

BEHAVIORAL HEALTH RESOURCES

➤ National Resources

- ✓ **Shelley Schuver** - *National Behavioral Health Recruiter* (Shelley_Schuver@teamhealth.com)
- ✓ **Richard Juman, PsyD** - *National Director of Psychology* (Richard_Juman@teamhealth.com)
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- ✓ **Joycelle Johnson** - *Executive Assistant to Brad Markowitz, National Senior Vice President, Post-Acute Care*
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- ✓ **Wayne Tasker, PhD** – *Southeast Regional Director of Behavioral Health & Behavioral Health Clinical Educator*
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