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## Trauma informed care

Adverse childhood experiences and its implications for health care

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Credit: Dr. Kay Ayre; Trauma Informed Positive Behaviour Support

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## Overview

- Psychosocial complexity: Childhood adversity & post-traumatic stress
- Impact of traumatic toxic Stress (TTS) on biopsychosocial functioning
- Trauma informed care (TIC): Approaches to reducing the burden of ACEs
- Implementation: Barriers and opportunities.
- Case studies
- Discussion and questions

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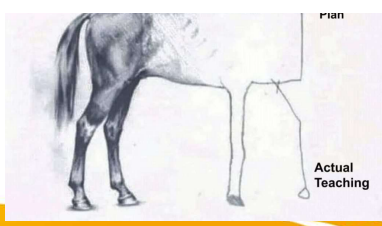
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## Teaching in 2020



View materials, citation and similar papers at CORE.AC.UK

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**Questions to consider - Survey**

- What challenges do your clients face in treatment?
- What makes these challenges difficult for clients?
- How have you helped clients with these concerns?
- <https://www.surveymonkey.com/r/APASeminar>


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Behaviour as communication: Generating hypotheses

**WHAT CHALLENGES DO YOUR CLIENTS FACE IN TREATMENT?**




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**Childhood adversity**

Research Article

**Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults**

**The Adverse Childhood Experiences (ACE) Study**

Vincent J. Felitti, MD, FACP, Robert F. Anda, MD, MS, Dale Nordenberg, MD, David F. Williamson, MS, PhD, Alison M. Spitz, MS, MPH, Valerie Edwards, BA, Mary P. Koss, PhD, James S. Marks, MD, MPH




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Dr. Felitti made the connection that overeating made patients feel better by soothing their anxiety, fear, anger, or depression and losing weight increased their anxiety, fear, and depression to levels that were intolerable. He introduced his findings at a convention in Atlanta, where he met Dr. David Williamson and Dr. Robert Anda, both medical epidemiologists for the CDC. These three doctors and their colleagues began laying out the criteria for the ACE Study to understand how childhood events might affect adult health.<sup>17</sup> The ACE Study was designed to answer the question: "If risk factors for disease, disability, and early mortality are not randomly distributed, what early life influences precede the adoption or development of them?"<sup>18</sup>

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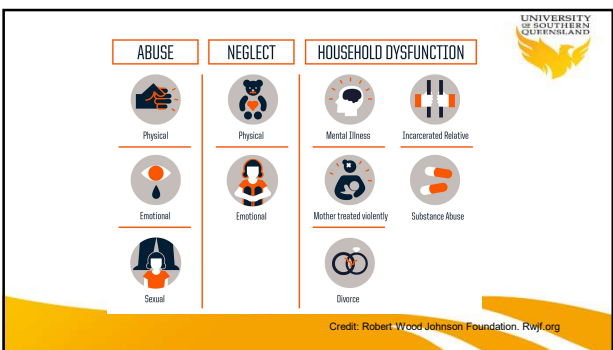
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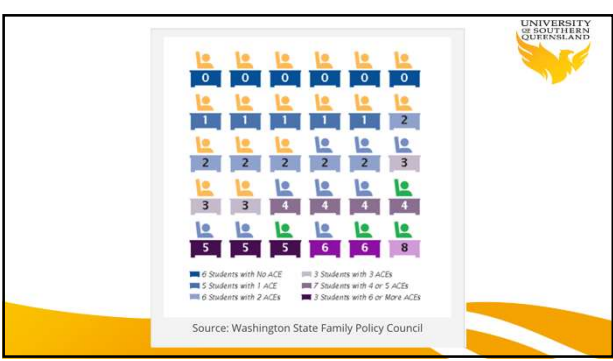
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**Adverse Childhood Experiences**  
Traumatic events that can have negative, lasting effects on health and wellbeing

**4 or more ACEs**

- 3x the levels of lung disease and adult smoking
- 11x the level of hypertension (high blood pressure)
- 14x the number of suicide attempts
- 4x the likely to have been incarcerated by age 15
- 4.5x more likely to develop depression
- 2x the level of liver disease

**Abuse**  
Emotional abuse  
Physical abuse  
Sexual abuse

**Household Challenges**  
Substance abuse  
Mental illness  
Domestic violence  
Parental separation/divorce  
Unemployment

**Neglect**  
Emotional neglect  
Physical neglect

People with 4+ ACEs can die **20 yrs** earlier than those who have none

1/3 of the population have more than 4 ACEs

**67%** of the population have at least 1 ACE

**Adverse Childhood Experiences are the single greatest unaddressed public health threat facing our nation today.**

By Robert Block, Professor, Institute of the Behavioral Sciences of Harvard

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**Trauma and Social Location**

Adverse Childhood Experiences | Historical Trauma/Embodiment

<http://www.acesconnection.com/blog/adding-layers-to-the-aces-pyramid-what-do-you-think>

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Psychological impact of childhood adversity

**POST TRAUMATIC STRESS**

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### Trauma

The exposure to a stressful event or situation of exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone.



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Natural / Accidental vs. Social / Interpersonal

Type 1: Single Incident vs. Type 2: Multiple / Cumulative

9/11... NEVER forget

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**PTSD and complex PTSD symptoms**

source: European Journal of Psychotraumatology 2013, 4, 20708  
http://dx.doi.org/10.3402/ejpt.v4i0.20708

Sense of threat	Interpersonal disturbances
Avoidance	Negative self-concept
Re-experiencing	Affect dysregulation
	Sense of threat
	Avoidance
	Re-experiencing

PTSD vs. Complex PTSD

<http://traumadissociation.com/complexptsd>

Overlap with pain and other symptoms; impact on health-related behaviours

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**Neurological impact and toxic stress**

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**HOW I PICTURED MYSELF DURING THE APOCALYPSE**      **WHAT I REALLY LOOK LIKE!**



The slide features a title 'Neurological impact and toxic stress' and the University of Southern Queensland logo. It contains two contrasting images: a man in a black leather jacket holding a gun, representing a common 'apocalypse' trope, and a woman in a beige coat standing in a grocery store aisle, representing the actual reality of the situation.

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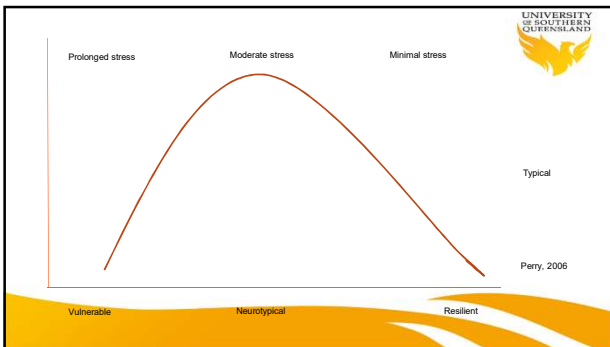
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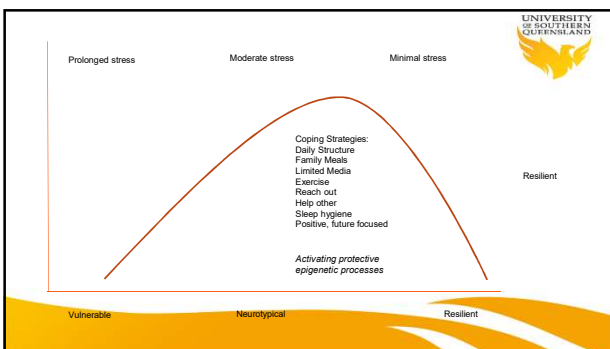
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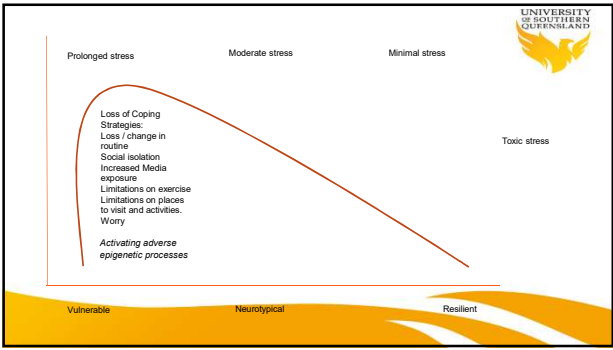
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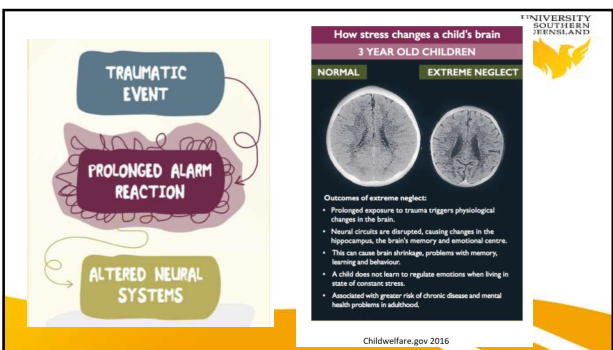
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**Attachment coping**

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Attachment is a type of behaviour displayed by children to draw their primary caregiver towards them at moments of need or distress. Bio-behavioural feedback system.

Early attachment relations are crucial for later social relationships and for the development of capacities for emotional and stress regulation, and learning.

Children who have had insecure attachments are more likely to struggle in these areas and to have emotional, behavioural and cognitive difficulties

(National Institute for Health and Care Excellence (NICE), 2016)

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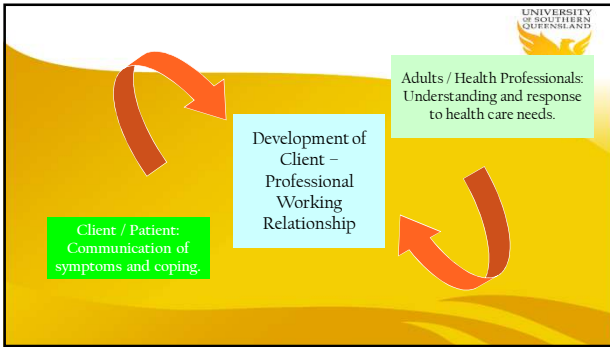
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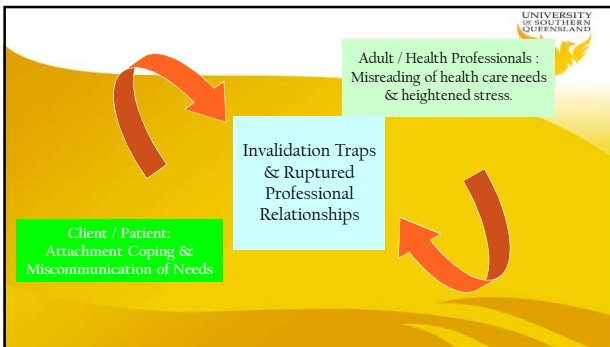
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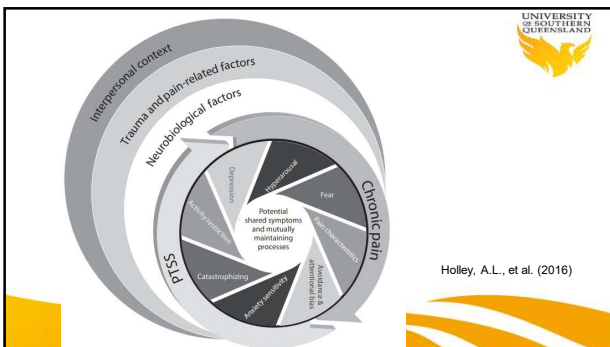
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Approaches to reducing the burden of ACEs

## TRAUMA INFORMED CARE

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**Table 1. Primary, secondary, and tertiary response to adverse childhood events**

Phase	Goal	Examples
Primary prevention	Prevent the occurrence of adverse childhood events so that fewer children experience ACEs	<ul style="list-style-type: none"> <li>Programs that prevent child abuse and neglect</li> <li>Programs that increase family and community stability and resilience</li> <li>Programs that teach positive and effective parenting skills</li> </ul>
Secondary prevention	Reduce the severity and acute consequences of the child adverse experience, thereby reducing the incidence of adverse outcomes associated with ACEs	<ul style="list-style-type: none"> <li>Programs that identify and intervene on families experiencing violence and abuse</li> <li>Trauma informed care to identify and immediately intervene on ACEs</li> <li>Psychological first aid that reduces psychological impact of trauma</li> </ul>
Tertiary prevention	Treat and reduce the long-term consequences of ACEs	<ul style="list-style-type: none"> <li>Trauma informed care in health care and service agencies that integrate past traumatic experiences into, for example, care for chronic illnesses</li> <li>Programs that identify and reduce risky health behaviors associated with ACEs</li> <li>Social marketing campaigns that build empathy with ACE consequences</li> </ul>

These phases are cyclical and can influence each other. For example, an individual who has an ACE-related health outcome may be less likely to introduce ACEs into the life of their child if they have received trauma informed care to reduce the consequences of their health outcome. ACE, adverse childhood experience.

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### Secondary Prevention: Trauma informed care

**Safety**




Ensuring physical and emotional safety

**Choice**




Individual has choice and control

**Collaboration**




**Definitions**  
Making decisions with the individual and sharing power

**Trustworthiness**



Task clarity, consistency, and interpersonal Boundaries

**Empowerment**



Prioritizing empowerment and skill building

**Principles in Practice**

Common areas are welcoming and privacy is respected

Individuals are provided a clear and appropriate message about their rights and responsibilities

Individuals are provided a significant role in planning and evaluating services

Respectful and professional boundaries are maintained

Providing an atmosphere that allows individuals to feel validated and affirmed with each and every contact at the agency

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**Tertiary prevention:  
Trauma informed positive behaviour support**

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*JAMA Pediatr.* 2016 January ; 170(1): 70–77. doi:10.1001/jamapediatrics.2015.2206.

**Implementing a Trauma-Informed Approach in Pediatric Healthcare Networks**

Meghan L. Marsac, PhD<sup>1,2</sup>, Nancy Kassam-Adams, PhD<sup>1,3,4,5</sup>, Aimee K. Hildenbrand, MS<sup>1,6</sup>, Elizabeth Nicholls, MS<sup>1,6</sup>, Flaura K. Winston, MD/PhD<sup>1,3</sup>, Stephen S. Leff, PhD<sup>1,3</sup>, and Joel Fein, MD, MPH<sup>1,3,5</sup>

<sup>1</sup>The Center for Injury Research and Prevention, The Children’s Hospital of Philadelphia  
<sup>2</sup>Department of Psychiatry, University of Pennsylvania  
<sup>3</sup>Department of Pediatrics, University of Pennsylvania  
<sup>4</sup>Center for Pediatric Traumatic Stress, The Children’s Hospital of Philadelphia  
<sup>5</sup>Division of Emergency Medicine, Department of Pediatrics, University of Pennsylvania  
<sup>6</sup>Department of Psychology, Drexel University

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**Prepare for spread**

Actions:

- Engage executive leadership in supporting trauma informed care initiatives (e.g., provide information on patient and staff outcomes)
- Design leaders to champion the desired changes by creating partnerships with departments and/or clinical group
- Initiate early communication across the institution about why trauma-informed care is important

Questions:

- Does this institution value trauma-informed care?
- Is the institution ready for this shift in care?
- What resources are available to support training and implementation of trauma-informed care?
- What resources are available to support staff as self-care?
- Does the institution have the experience/incentive to lead trauma-informed care training or are external consultants needed?

**Establish an aim for spread**

Actions:

- Determine which departments/clinic groups will first receive training
- Define goals (e.g., 90% of direct care staff will complete a trauma informed care seminar; staff confidence in preventing/minimizing medical traumatic stress will increase; patient satisfaction scores will increase; staff job satisfaction will increase)
- Set a timeline

Questions:

- What type of training will be provided?
- Will each training be tailored to that department/clinic or will everyone receive the same information?
- Will training be multi-disciplinary or discipline specific?
- How will the training be delivered?
- How will training be sustainable over time?
- How will goals be measured?

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- Determine who is on the decision-makers about training and implementing trauma-informed care practices
- Plan for who will be responsible for the trauma-informed care training program once the decision is made to initiate training
- Identify barriers to training (e.g., no room in the lecture schedule, need for additional buy-in from leadership and providers, concerns that identifying more trauma will result in more referrals)
- Collect feedback/data as plan begins (e.g., is the training relevant, is more training needed, do departments support the implementation of the skills learned in the training)

Questions:

- What are the current attitudes towards trauma-informed care training?
- Are some trauma-informed care practices already occurring? If so, how can we build on them?
- How does the feedback/data suggest a need for changes in the training program?
- Is it best to start with one department and to should everyone be trained simultaneously?
- How are rotating trainees (e.g., residents) provided the training?
- Can cost-effectiveness be demonstrated?

JULIE BRADLEY

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Julie Bradley

## CASE STUDIES

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## QUESTIONS?

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**References**



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