Beyond the Traumatic Experience

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Prevalence of Traumatic Experience

In the United States "traumatic event exposure using *DSM-5* criteria was high (89.7%), and exposure to multiple traumatic event types was the norm."

J Trauma Stress. 2013 Oct; 26(5): National Estimates of Exposure to Traumatic Events and PTSD Prevalence Using DSM-IV and DSM-5 Criteria. Dean G. Kilpatrick et al.

From the Greek

- τραύμα = Wound

Potential Traumatic Events

Not every event is a cause of trauma. Everything depends on how the person experiencing it deals with it.

But there are lots things that can bring about a traumatic reaction.

Just consider this list. And, of course, admission to the hospital is a significant event in anyone's life.

What is trauma?

- …direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior) DSM IV-TR

TRAUMATIC EVENTS

Exhibit 1.2-1: Trauma Examples

Caused Naturally	Caused by People	
	Accidents, Technological Catastrophes	Intentional Acts
Tornado	Train derailment	Arson
Lightning strike	Roofing fall	Terrorism
Wildfire	Structural collapse	Sexual assault and abuse
Avalanche	Mountaineering accident	Homicides or suicides
Physical ailment or disease	Aircraft crash	Mob violence or rioting
Fallen tree	Car accident due to malfunction	Physical abuse and neglect
Earthquake	Mine collapse or fire	Stabbing or shooting
Dust storm	Radiation leak	Warfare
Volcanic eruption	Crane collapse	Domestic violence
Blizzard	Gas explosion	Poisoned water supply
Hurricane	Electrocution	Human trafficking
Cyclone	Machinery-related accident	School violence
Typhoon	Oil spill	Torture
Meteorite	Maritime accident	Home invasion
Flood	Accidental gun shooting	Bank robbery
Tsunami	Sports-related death	Genocide
Epidemic		Medical or food tampering
Famine		
Landslide or fallen boulder		

Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series, No. 57. Center for Substance Abuse Treatment (US). Rockville (MD)

Commonly overlooked causes of emotional and psychological trauma

- Falls or sports injuries
- Surgery (especially in the first 3 years of life)
- The sudden death of someone close
- A car accident
- The breakup of a significant relationship
- A humiliating or deeply disappointing experience
- The discovery of a life-threatening illness or disabling condition
- Visit to an emergency department or admission to a hospital

What makes an event 'traumatic?'

- …**a traumatic event or situation creates psychological trauma when it overwhelms the individual's ability to cope**, and leaves that person fearing death, annihilation, mutilation, or psychosis. The individual may feel emotionally, cognitively, and physically overwhelmed. The circumstances of the event commonly include abuse of power, betrayal of trust, entrapment, helplessness, pain, confusion, and/or loss. Sidran Institute

http://www.sidran.org/resources/for-survivors-and-loved-ones/what-is-psychological-trauma/

POLL QUESTION: Knowledge of Trauma-Informed Care

How well are you informed about the effects of trauma on the brain?

1. Well informed.
2. Somewhat informed.
3. Not sure.
4. Don't know about it.

REACTIONS TO A SITUATION THAT BECOMES TRAUMATIC

Stress-Trauma-Crisis Continuum

- A PERCEIVED THREAT OR DIRE EXPECTATIONS
- PRESSED BEYOND USUAL COPING SKILLS
- DEFENSIVE FEELINGS AND REACTIONS
- CHANGES ONE'S FUNDAMENTAL UNDERSTANDING OF LIFE, DISRUPTION OF LIFE

Assessment is critical: Don't project our expectation that a person has been traumatized by something we believe should be traumatic.

(Dulmus, 2003)

The BRAIN REACTS

In situations perceived as threats
the primitive brain overrides common
cognitive abilities and releases chemicals
to prepare the body to fight the aggressor or
to run away as quickly as possible.
…in a fraction of a second…

'TRAUMA IS BODILY CHANGES.'

Physical Signs of Trauma

- Insomnia or nightmares
- Being startled easily
- Racing heartbeat
- Aches and pains
- Fatigue
- Difficulty concentrating
- Edginess and agitation
- Muscle tension

David W. Krueger (2002)

Emotional and psychological symptoms of trauma

- Shock, denial, or disbelief
- Repetitive, intrusive memories
- Anger, irritability, mood swings
- Guilt, shame, self-blame
- Feeling sad or hopeless
- Confusion, difficulty concentrating
- Anxiety and fear
- Withdrawing from others
- Feeling disconnected or numb
- Flat affect

Sound familiar?

Do these symptoms remind you of another event that we are used to treating for?

GRIEF!

Effects of Trauma on Brain

- ***Flood of negative emotions or 'frozen with fear'***
- ***Reduce ability to think or analyze***
- ***Reduce ability to relate to other people***

What we generally do?!

We talk; we explain; we invite them to share; we seek to make an emotional connection; we ask them to understand what is going on (if professional, or to make sense of things if we are religious)

Primitive Survival-Mode Reactions

- Fight – Resist, Contest, Refuse, Argue, Accuse
- Flight – Leave, Run
- Freeze – Shut down, Sleep, 'Play dead,' Deny
- ***Admission to the hospital is itself a traumatic event in addition to whatever is going on with the patient's body.***
  - *Doubly traumatic: Physical injury or illness + emotional reactivity (active and passive)*

We want and need the cooperation of the patient and family exactly at a time when they may be least able to make calm, rational decisions
We expect patients/families to do precisely what they cannot do in the traumatic moment: think, control feelings, make sense of things, understand.

ASSESSMENT: INDICATORS OF TRAUMATIC REACTION

- Tense, edgy, anxious
- Worried, fearful
- Critical, angry, loss of emotion control
- Watchful, vigilant, 'on guard'
- Poor memory
- Confusion
- Need for things to be repeated
- Not retaining/integrating information

ASSESSMENT: INDICATORS OF TRAUMATIC REACTION

- Sad, somber, 'heart-broken'
- Isolated
- Frozen, stuck
- Defocused, not relating to or connecting with others
- Frightened
- Denial, non-acceptance, refusal to accept situation
- Demanding
- Sad memories, flashbacks

Cognitive Reactions to Trauma

Immediate Cognitive Reactions

- Difficulty concentrating
- Rumination or racing thoughts (e.g., replaying the traumatic event over and over again)
- Distortion of time and space (e.g., traumatic event may be perceived as if it was happening in slow motion, or a few seconds can be perceived as minutes)
- Memory problems (e.g., not being able to recall important aspects of the trauma)
- Strong identification with victim

Delayed Cognitive Reactions

- Intrusive memories or flashbacks Reactivation of previous traumatic events
- Self-blame
- Preoccupation with event
- Difficulty making decisions
- Magical thinking: belief that certain behaviors, including avoidant behavior, will protect against future trauma
- Belief that feelings or memories are dangerous
- Generalization of triggers (e.g., a person who experiences a home invasion during the daytime may avoid being alone during the day)
- Suicidal thinking (NCBI, 2011)

Grounding Techniques: Summary

- Ask the patient to what he or she observes. *What do you notice around you? Can you see me? Where are you now?*
- Help the patient decrease the intensity of affect. *"Dial down" your emotion. Make a fist and then slowly release it. Take a few deep breaths – in through your nose, out through your pursed lips.*
- Distract the patient from unbearable emotional states. *Ask general questions. Wiggle the toes; gentle rocking; warm cloth.*
- Ask the patient to use breathing techniques. *Focus on breathing.*

Trauma-informed care. NCBI.

A Direct APPROACH TO TRAUMA

- Do things that are effective in **calming and soothing people**:
  - a calm presence, soft voice, speaking slowly
  - few questions
  - soothing reassurance
  - help with breathing/relaxing
  - picture, music
  - slowly read scripture or prayer
  - a warm blanket
  - quietness, show concern
  - Touch, comfort,
- SPEAK AS LITTLE AS POSSIBLE; DON'T ASK; LISTEN

Bodies in Emotional trauma

- Prayer and meditation stimulate reconnection to the frontal cortex
- Meditation and mindfulness calm the amygdala
- Calming, breathing, soothing
- Include physiology in care, relaxation, e.g., a warm blanket
- Recognizing that people who will not accept anything to help them relax are NEEDING to stay on guard for protection – this is not a conscious choice.

- "The Body Keeps the Score" – van der Kolk

Healing process strategies

- "Finding safety and trust is the first step to healing." (Hall, 2008)
- Being emotional is part of the healing. Share sensations of the body. Stay in touch with how the body is feeling. This helps us to feel safe. Maintain awareness.
- If patient seems disconnected, ask what they see around them, colors, sounds, smells.
- If a person becomes defensive, don't press them.
- Find out if there is any pleasant sensation along with the bad; go back and forth.
- Listen to negative feelings with acceptance.
- Make a list of things that help person feel safe and strong.
- Work on improving breathing; relaxing.

Types of Touch

- Task touch – if hurried may be perceived as cold or uncaring; gentle communicates warmth, caring, support, and reassurance
- Caring touch – touching the patient when there's no physical need to. It can be intended o encourage clinical progress, such as placing an arm around the shoulders, hugging, or giving a pat on the back. Of it can be comforting – hand-holding, say, or stroking, massaging, or even hair brushing. Comforting touch is often used to alleviate discomfort or the grief associated with illness or dying.
- Specific clinical applications
  rubbing painful area, comforting touch, hand-holding

Talton, 1995

Benefits of being touched

- Feel connected to others
- Reduces anxiety
- Creates bonding
- Reduces blood pressure
- Improves outlook
- Provides the sensory input we crave

Trauma care brief practices (1)

- Reduce information overload; give opportunity to share the stress; be empathically attuned; give smaller bits of care plan with lots of reassurance
- Breathing regulation
  - Breathe in through nose count of 3; breathe out through pursed lips count of 6
- Relaxation technique
- Hand warming technique for relaxation and pain control. Imagine the heat in your right hand increasing; imagine warmth coming down your right arm. Repeat several times a day for 5 minutes each time.
- Orient them into the room by asking them to describe what they see, hear, and smell.

Trauma care brief practices (2)

- Containment posture
  - Right hand under arm beside the heart; left hand on right shoulder. Feel this and breathe normally
- Remember a beautiful place one has been and re-experience that occasion as fully as possible.
- Sit quietly with the patient/family member even for just a few moments.
- Recognize, mirror, and reinforce indications of resilience factors that would modulate or protect for traumatic reactions: optimism, enjoys planning, support system, gratitude, sense of humor, enjoys learning, generosity, religious/spiritual, self-directed, high self-esteem, self-confidence, controls emotions, has a purpose in life, believes he/she makes a difference, flexibility, considers options, strong role models, willing to change, adaptability, feels life has meaning

Spiritual Practices for those caring for persons in trauma

- Prayer affirming the care of God in the present moment
- Use scripture that is affirming and hopeful, not judgmental or doctrinal.
- Allow person to speak of faith or belief but do not engage in discussion at this time.
- Try to protect traumatized person from people who would silence them or try to tell them how to think or feel or how not to think or feel.
- Recognize indications that the person is beginning to relate to others.
- Assist in arrangement for the next few hours of care; plan to visit again soon.
- Trust the healing process to work; be aware of any signs of loss of connection, inability to make decisions, withdrawal into self, alcohol or drug abuse, hurtful expressions of anger toward self or others.

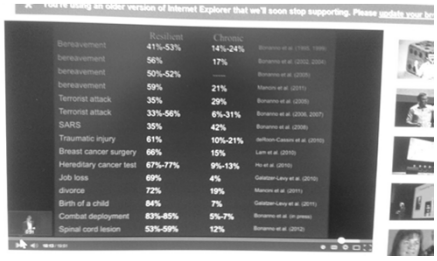
Spiritual Practices for caregivers of persons in trauma

- Silent, attentive, focused presence of love and care
- Comforting touch if welcome
- Breath prayer
- Speak in slow, quiet, voice affirming support
- Welcome displays of strong emotion; assess limits
- Provide for physical comfort
- Avoid assurances based on future experiences or expectations; stay in the moment. Avoid asking questions, let family decide.

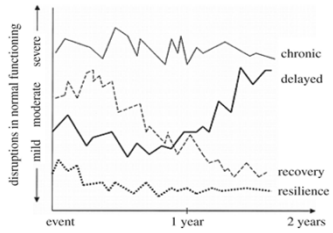
Bouncing Back

- The research of Bonanno et al demonstrates that persons with resilience come out of their trauma experience faster than those with weak resilience.
- Chaplains will observe patients who get reoriented rather quickly to themselves and the situation.

RESILIENCE IN THE FACE OF TRAUMA



RESPONSE TRAJECTORIES TO PERCEIVED TRAUMATIC EVENTS



Resilience factors

- Optimism
- Enjoys learning
- Support system
- Gratitude
- Sense of humor
- Religious/Spiritual
- Enjoys planning

Generosity
Self-directed
High self-esteem
Self-confidence
Emotional control
Purpose in life
Make a difference

Flexibility
Considers options
Strong role models
Willing to change
Adaptability
Life has meaning

Resilience-led responses to trauma

- Patients may quickly become oriented and grounded and able to think through options and make decisions
- Resilience quickly kicks in for dealing with the situation.
- Emotions could be kept under control to deal with the emergency – perhaps to appear later.
- Caregivers need to assess the patient carefully and respond appropriately – soothing/supportive:informational/personal
- Positive choices already made. Integrative narrative begun.
- Developing a healing story.
- Evidence of use of religious or spiritual resources.

Alternatives of trauma-informed spiritual care

- Following an experience that is perceived by the patient to be traumatic, two styles of spiritual care seem possible.
  - 1. Those with high resilience can be recognized for their accomplishment of coming through the trauma. They are demonstrating that their resilience was "pre-loaded" and has come into play.
  - 2. Those with lower resilience would need more supportive, encouraging care as their resources are slower (or fewer) in responding to the trauma thus showing that more nurturing care could be useful.

IMPLICATIONS for Beyond the Traumatic Experience

- ASSESS FOR TRAUMATIC REACTIONS IN PATIENT AND/OR FAMILY
- USE PSYCHOLOGICAL/SPIRITUAL INTERVENTIONS BASED ON YOUR ASSESSMENT
- WATCH FOR THE APPEARANCE OF BEHAVIORS THAT INDICATE POTENTIAL INFLUENCE OF RESILIENCE
- BROADEN THE NUANCED VERSIONS OF ASSESSMENT AND YOUR RESPONSES
- WHEN THE PRESENCE OF TRAUMA DIMINISHES USE THE THERAPEUTIC STYLE OF TRADITIONAL CHAPLAINCY

Resources

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