
PTSD
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Hudson-Crawford

Trauma destroys the social systems of care, protection, and meaning that support human life. The essential features of psychological trauma are ***disempowerment*** and ***disconnection*** from others.

(Judith Herman 1998)

Billy Connolly

To self-regulate we need……

01	02	03	04	05	06	07	08	09
Safety/ stability	Predictability/ consistency	Responsive and available care-givers	Affection/love	Nurturing/ care	Validation/ recognition/ attention	Help to understand feelings	Guidance/ boundaries	Respect/ understanding

“The pathogenic qualities of shame and self-criticism have been linked to two key processes. The first quality is the degree of self-directed hostility, contempt and self-loathing that permeates self-criticism. Second is the relative inability to generate feelings of self-directed warmth, soothing, reassurance and self-liking.”

(Gilbert & Proctor, 2006)

“People can even risk death and serious injury in order to avoid shame and ‘loss of face’. Not only can shame influence vulnerability to mental health problems but also……abilities to reveal painful information, various forms of avoidance (e.g., dissociation and denial) and problems in help seeking”.

(Gilbert & Proctor, 2006)

“What we don’t need in the midst of struggle, is shame for being human.”

Brene Brown

Key Points

- We do not think there are right and wrong ways to manage your emotions and the things that trigger them.
- There are only ways that work well or not so well
- This will depend on various things, including:
  - The long and short-term effects
  - If it help or hinders your personal goals and values
  - How it affects others
- We focus on changing what doesn’t work

My problem with the term ACES

37 M. Now deceased (DRD)	54 F Currently alcohol dependent. On OST	63 M Currently homeless & self harming
2 Y.O. physical abuse	15 Y.O. Rape	3 Y.O. old, in care after 2 Y.O. CSA
3 Y.O. child protection register	16 Y.O. OD 1984 Neurotic personality	4-6 Y.O. CSA while in care 13 Y.O. self harm rt forearm
5 Y.O. removed into care	17 Y.O. OD	16 Y.O. intentional hanging
11 Y.O. self harming	22 Y.O. Prison, culpable homicide	17-22 18 episodes OD or cutting
12 Y.O. paracetamol OD	23 Y.O. SVD	17-22 10 episodes OD
13 Y.O. Anger reaction	24 Y.O. Child removed	23 Psychopathic PD
16 Y.O. deliberate OD (Methadone)	25 Y.O. neurotic depression	24-32 Y.O. 24 episodes of DSH
19 Y.O. Stabbed in fight 19 Y.O. Prison, started OST	2000 Alcohol dependence 2003 OD	32- current, married 3 x, 19 children
22 Y.O. EUPD	2008 OD 2016 Opioid dependence	Break up in last relationship, now cutting again

What does trauma look?

TRADITIONAL VIEW	TRAUMA INFORMED VIEW
Acting out	Emotionally disregulated
Anger management problems	Scared/fight, flight, freeze
Willful and naughty	Maladaptive patterns
Manipulative	Seeking to get needs met
Uncontrollable	Lacking skills
Pushing buttons	Negative template or worldview
In need of consequences to motivate	In need of skills to self-regulate
Slow/delayed	Dissociative

Q. What happened to you?

Spoiler alert: some may not know, some may normalise horrible experiences, some may think its no more than they deserve.




What pushes my buttons?

Understanding Emotions Using the Trigger Log

Part of emotional awareness

- The ability to understand what specific emotion(s) we are feeling, the specific cause, and how to respond.
- Useful when our reactions are so automatic that we no longer question what we are feeling, why we are feeling it, or our response to it.

Emotional Understanding is not:

- Having definite/complete answers
- Justifying how you feel
- “Self-pity” or “making excuses”

Emotional Understanding is:

- Empathy for yourself and your reactions
- Willingness to explore why you might feel and react as you do
- Understanding we have limited control of our emotions
- Viewing emotions as useful sources of information

A Phased Approach in Working with Trauma

- Evidence and clinical consensus advises a phased approach to trauma work (Cloitre, Courtois, Charuvastra, Carapezza & Stolbach, 2011)
- Within this framework, the tasks of Phase 1 are essential as they establish safety and stabilisation in present functioning
- Phase 1 work sets the ground for more detailed specialist work or may act as a standalone treatment if appropriate

A Staged Approach to Treatment

- **Stage 1 – Establishing safety** *(the focus of this workshop)*
- Stage 2 – Remembrance and mourning.
- Stage 3 – Reconnection with ordinary life.

- References:
  - Herman, J.L. (1992), *Trauma and Recovery: From Domestic Abuse to Political Terror.* London: Pandora.
  - Najavits, L.M. (2002), *Seeking Safety: Cognitive-Behavioural Therapy for PTSD and Substance Abuse*, London: Gilford Press.

Phase One: Safety and Stabilisation

- Establish therapeutic alliance.
- Education about trauma and its impact.
- Attention to basic needs including:
  - connection to resources
  - self-care
  - identification of reliable support systems.
- Focus on the regulation of emotion and the capacity to self-soothe.

Recognising our power & privilege

[INCLUDING IF ONE HAS LIVED EXPERIENCE]

- In the UK, peers working in collaboration or as employees tend to be people in recovery
- In some countries (Canada, Denmark, Australia) the term ‘peers’ primarily refers to people who are currently using drugs, in or out of services.
- In other words, our society tends to privilege one way of ‘being’ as better than any other way when one uses substances. This gives you power, that the majority of people who use substances (the ones most at risk) do not have.
- HOW WILL YOU USE THAT POWER?

“Do you know what people really want? Everyone, I mean. Everybody in the world is thinking: I wish there was just one other person I could really talk to, who could really understand me, who'd be kind to me. That's what people really want, if they're telling the truth.”

Doris Lessing, “The Golden Notebook.”

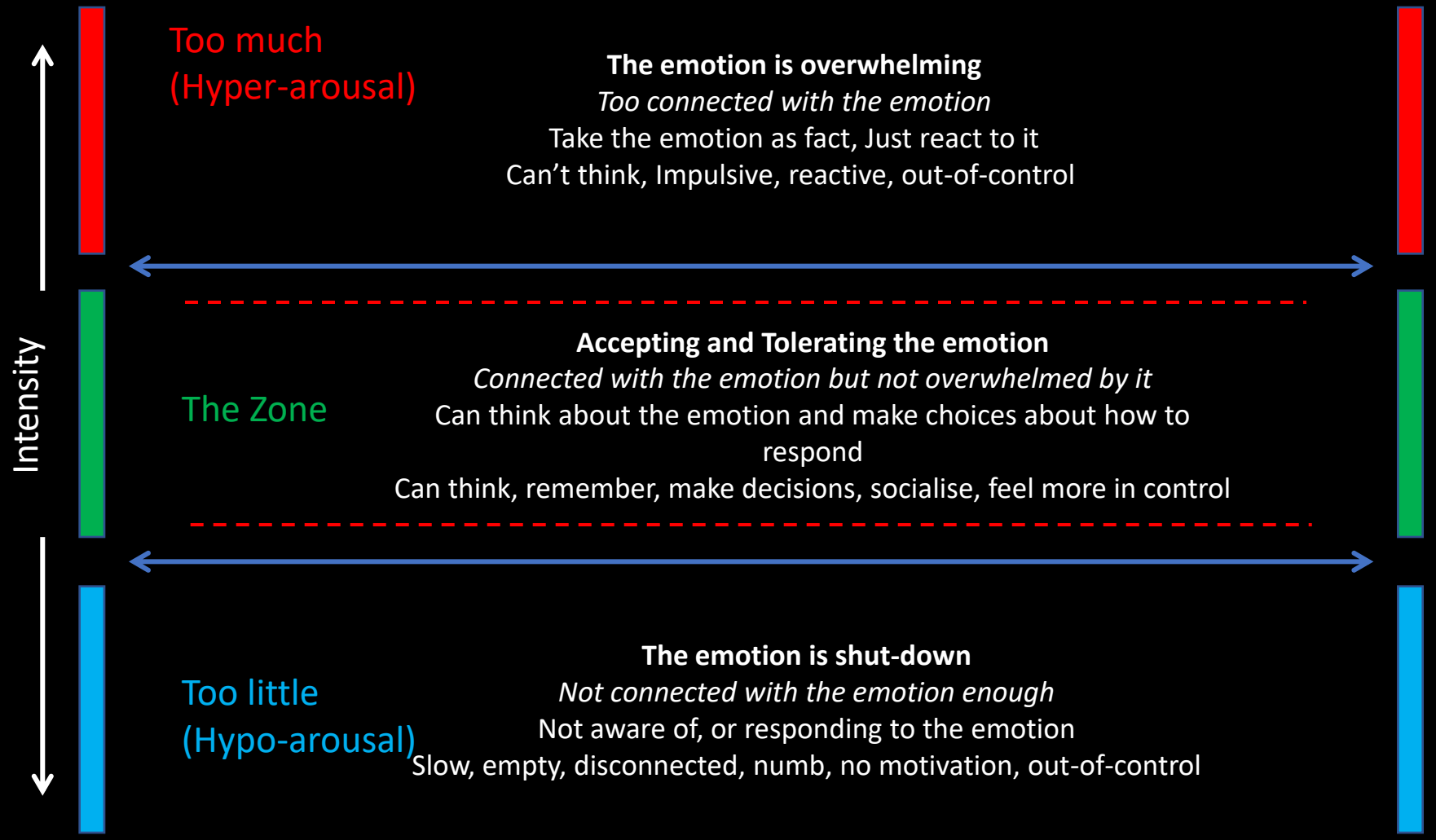
We get into habits of using unhelpful and often self-destructive ways to help us cope when we are upset

We then feel bad about this which only makes us feel worse and more likely to keep on doing them

We can break this vicious cycle by developing new habits which will help us feel better about ourselves and feel more in control

What is distress tolerance?

The Zone of Tolerance



Adaptation is defined as the implementation of coping strategies that enhance the recognition and processing of useful responses that increase, either in the short term or long term, more productive functioning, as defined by valued goals and purposes held by the individual.

Adaptive emotion regulation

toolbox for regulating emotions

Modify the situation either through problem solving, stimulus control, or change the person's perception through cognitive restructuring

If the problem is the increase in arousal and sensations then stress reduction techniques such as progressive relaxation, breathing exercises, and other self-calming may be useful

If the problem is how to cope with emotional intensity, then the person may find acceptance, mindfulness, and compassion-focused self-soothing helpful

If the difficulties are interpersonal the person may benefit from techniques addressed at validation or interpersonal functioning (e.g., learning skills to maintain friendships and social support)

My attempt at re-designing our OST service through a trauma-informed lens.

- **Safety.**
  - Creating spaces where people feel culturally, emotionally, and physically safe.
  - An awareness of an individual's discomfort or unease and adapting our manner and service accordingly.
  - Prescribing always to minimise harms and not to increase them
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- **Transparency and Trustworthiness.**
  - The service is clear & consistent from the outset in what it provides
  - The service will be guided by the following core principles:
    - People with opiate dependence will receive ORT treatment as quickly as possible, and prior to lengthy assessments or treatment planning sessions
    - Maintenance ORT is delivered for as long as the patient wishes
    - Individualized psychosocial services are continually offered but not required as a condition of ORT
    - ORT is discontinued only if it is worsening the person’s condition. It is never discontinued punitively.

- **Choice:** Providing a range of options to the patient which
  - Allow for flexibility, safety and as far as possible meets the needs of our patients
  - Are not inherently obstructive to engagement
  - Does not unnecessarily delay ORT commencement

- **Collaboration, Respect & Empowerment**
  - There are no mandated requirements as a prerequisite to treatment. In other words, plans for interventions such as psychosocial therapy must be developed collaboratively and not imposed.
  - Decisions to detoxify from ORT, engage in psychological work, group work and other therapy must come from the patient.
  - Drug test results are not used punitively as there is a “no involuntary discharge policy” relating to continued illicit drug use.
  - Patients share in all decisions made. As far as possible, these decisions are their own unless in may result in harms to others.
- **Low threshold:**
  - **Refers to the removal of barriers that limit or delay access to ORT.**
  - **The referral process is open so clients can be referred from any source, including self-referral.**
  - **Intake assessments are minimized**, focussing on addressing immediate risks (including driving & child protection), harm reduction and safe ORT initiation with other aspects of assessment occurring later (Treatment first)

Do’s & Don’ts for good practice ORT

- Do not delay ORT if at all possible. Do not delay ORT under any circumstances in someone who is at high risk harm (including during acute admissions)
- Do no initiate a taper or discontinuation of OST punitively (for example for not attending appointments)
- ORT is NOT contingent on patients engaging in psychosocial interventions
- THERE IS NO time limit on maintenance ORT
- Do not encourage rapid buprenorphine detoxification with the goal of transitioning to antagonist medications or no medications at all.
- Do not discharge a patient based on positive drug test results for illicit substances.
- Do not discharge a patient or transfer care without ensuring that every step possible is taken for a smooth transfer of their prescription
- ORT should not be delayed by staffing capacity to provide psychosocial services.
- Do make decisions on dosage and the treatment plan based on individual patient factors,
- If and when adherence to treatment is disrupted by patient circumstances or behaviours:
    - Do have a trauma informed approach to helping
    - Do increase accountability measures

ENCOURAGING STAFF WELLNESS IN TRAUMA-INFORMED ORGANIZATIONS

As health care provider organizations move toward becoming trauma-informed, ensuring emotional wellness among professional and non-professional staff is a crucial requirement for providing high-quality care.

CHRONIC EMOTIONAL STRESS IN HEALTH CARE STAFF...

SECONDARY TRAUMATIC STRESS, also known as compassion fatigue, is emotional duress that mimics post-traumatic stress disorder caused by hearing about another person's firsthand traumatic experiences.

VICARIOUS TRAUMATIZATION is the cumulative effect of consistent exposure to hearing about other people's traumatic experiences.

Indirect exposure to trauma can contribute to **BURNOUT**, a form of physical, mental, and emotional exhaustion caused by chronic work-related stress.

SYMPTOMS OF CHRONIC EMOTIONAL STRESS
Guilt, social withdrawal, anger, cynicism, chronic exhaustion, physical illness, inability to listen, and loss of creativity.

CAN LEAD TO

NEGATIVE ORGANIZATIONAL OUTCOMES...

POOR PATIENT CARE
Staff experiencing chronic emotional stress may not have the emotional resources to provide high-quality care and the resulting poor care may contribute to patients' re-traumatization.

HIGH STAFF TURNOVER
Staff who experience chronic emotional stress are more likely to leave the organization, which can cause dissatisfaction among other employees. Replacing staff is expensive and time-consuming.

MAY BE ADDRESSED WITH

STRATEGIES FOR PROMOTING STAFF WELLNESS

Encourage and incentivize self-care activities like counseling, meditation, exercise, and healthy eating.

Foster a culture that encourages staff to seek support, keeps caseloads manageable, and provides sufficient mental health and paid time off benefits.

Provide trainings that create awareness of chronic emotional stress and the importance of self-care.

Implement reflective supervision, during which time health care professsionals and their supervisors meet to address feelings about patient interactions.

A PRIORITY?

IF NOT, WHY???

Most Important!

Laughter is sometimes the best medicine