



**TRAUMA- INFORMED CARE-
A Team Approach to Managing Unwanted Behavior**

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Behavioral Health Federal Regulations

483.40 Behavioral Health Services

- Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
- Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders

Behavioral Health Federal Regulations

(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial wellbeing of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of facility's population in accordance with 483.70 (e)

Behavioral Health Federal Regulations

These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:

- Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to 483.70 (e), and
- Implementing non-pharmacological interventions

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;

Behavioral Health Federal Regulations

- A resident whose assessment does not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and /or post-traumatic stress disorder does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that the development of such a pattern was unavoidable.

Post-Traumatic Stress Disorder

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.

Early References to PTSD

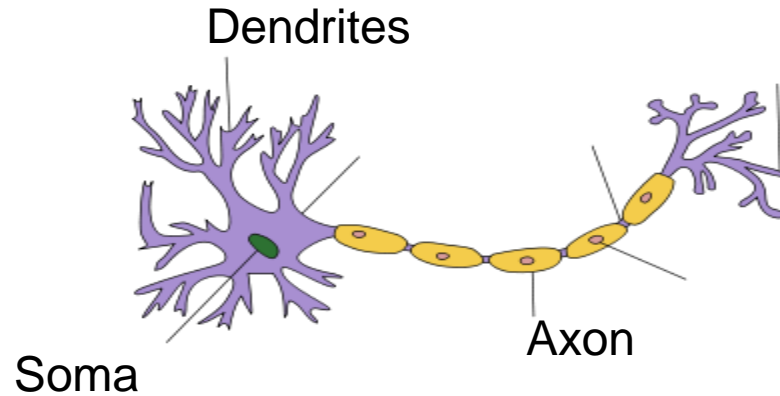
- 1. Homer's Odyssey
- 2. Great Fire of London (1666)
- 3. Civil War – Irritable Heart Syndrome
- 4. Railway Spine
- 5. Hysteria (1881)
- 6. Nervous Shock (1885)
- 7. Traumatophobia (1940's)
- 8. World War I Soldier's heart; shell shock
- 9. Combat fatigue, war neurosis, battle fatigue, etc. WWII
- 10. Rape Trauma Syndrome (1970)
- 11. DSM III (1980) First official recognition of PTSD as a diagnostic entity

There is a lot going on up there!!

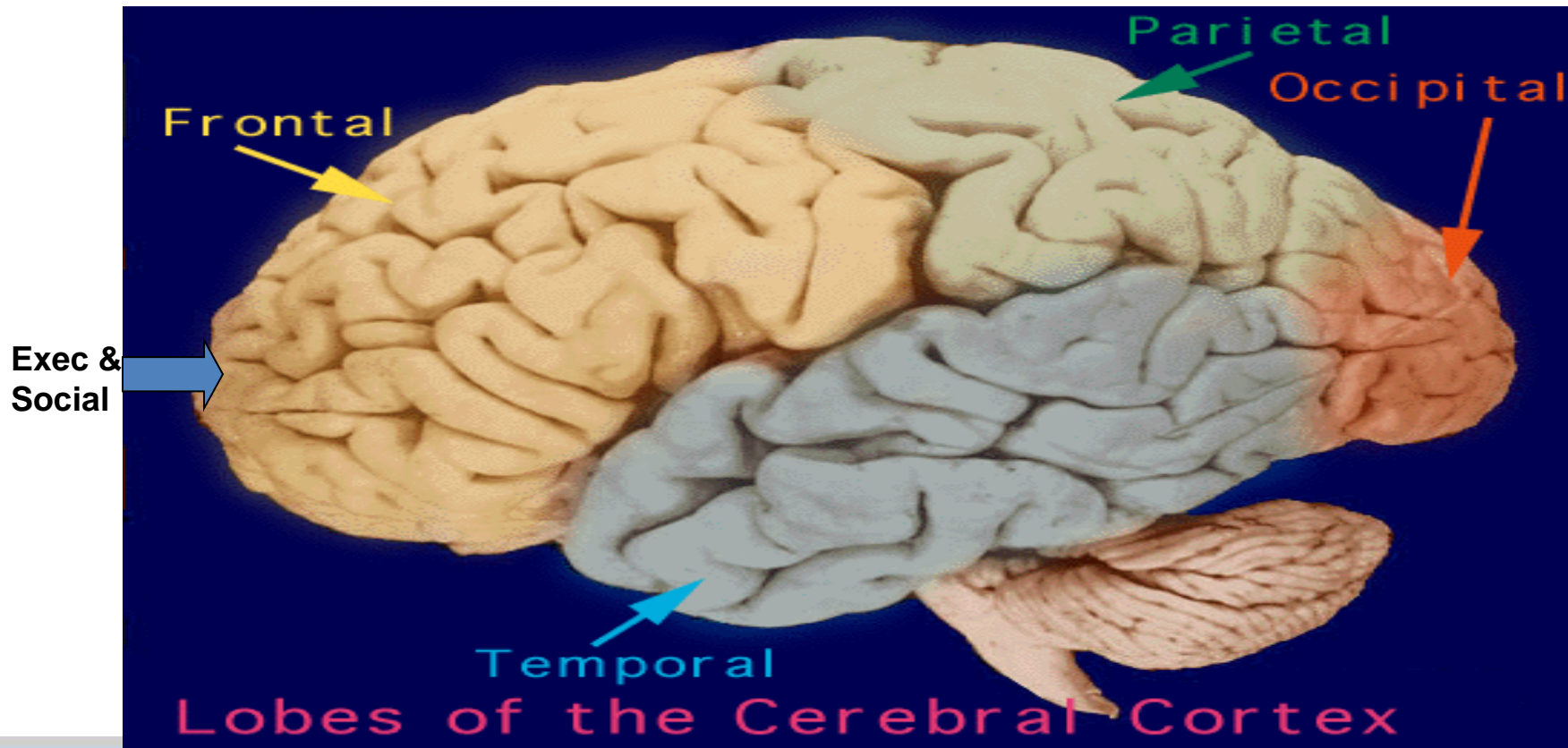


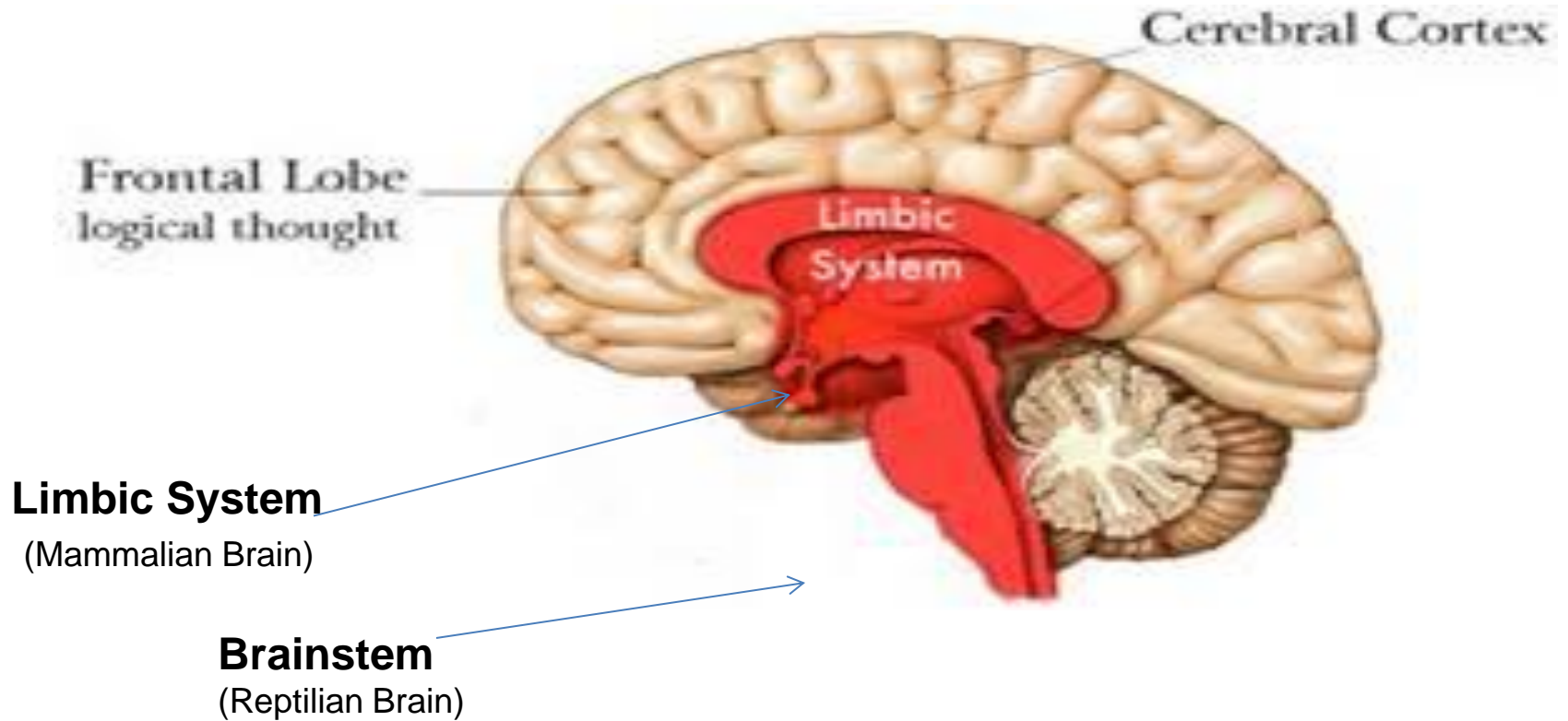
It All Starts Here

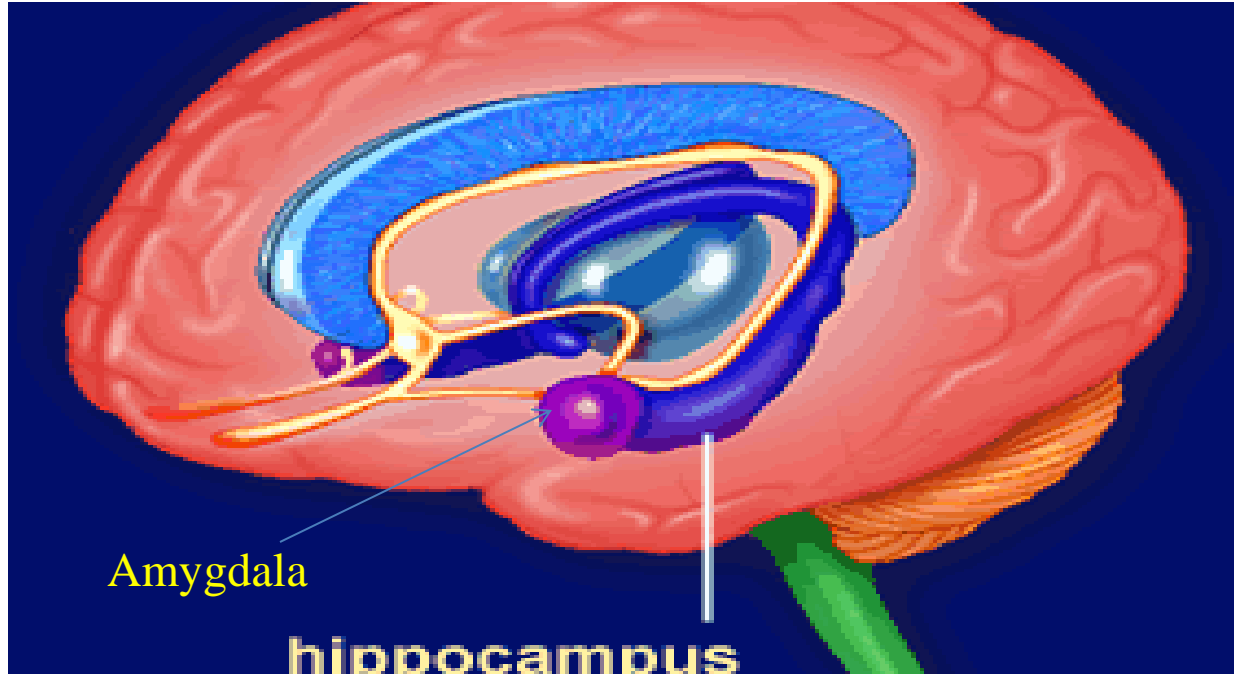
Structure of a neuron



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 versus 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

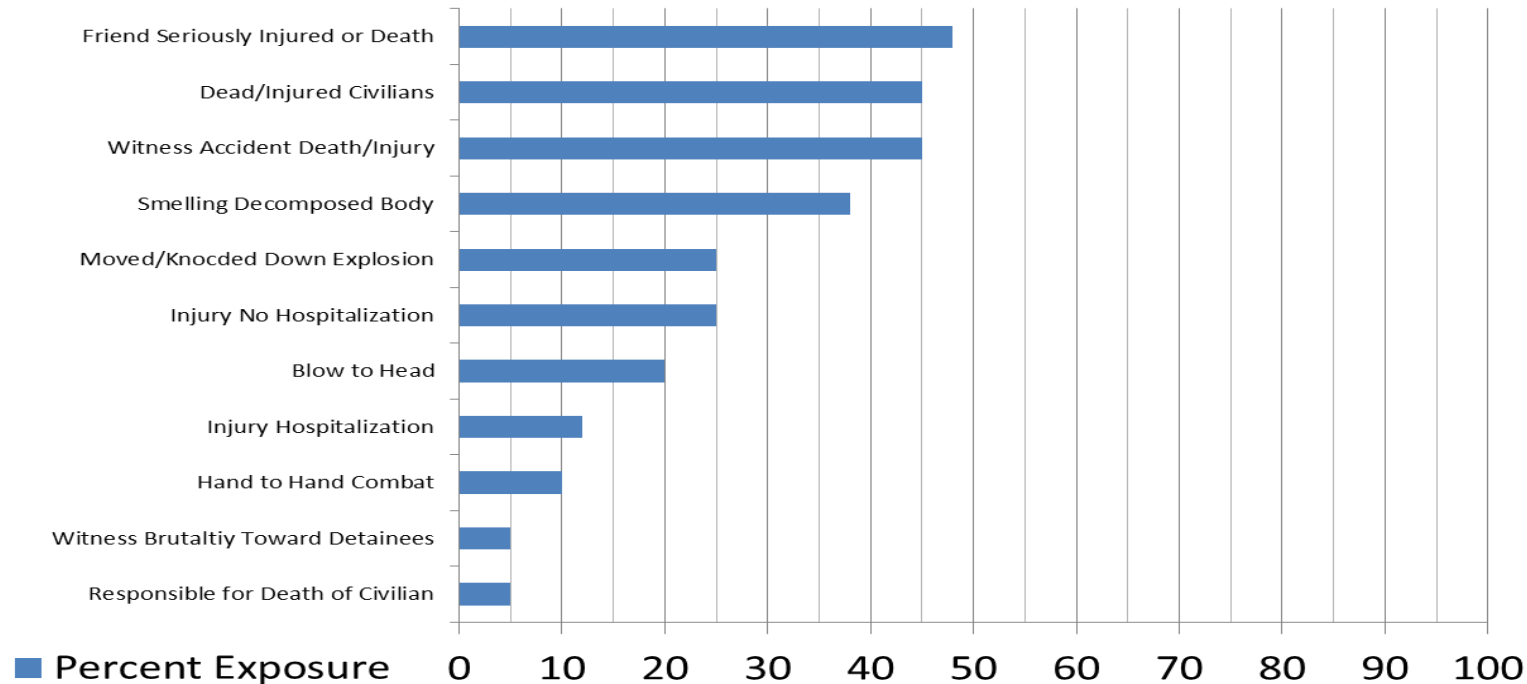
Posttraumatic Stress Disorder – DSM 5

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

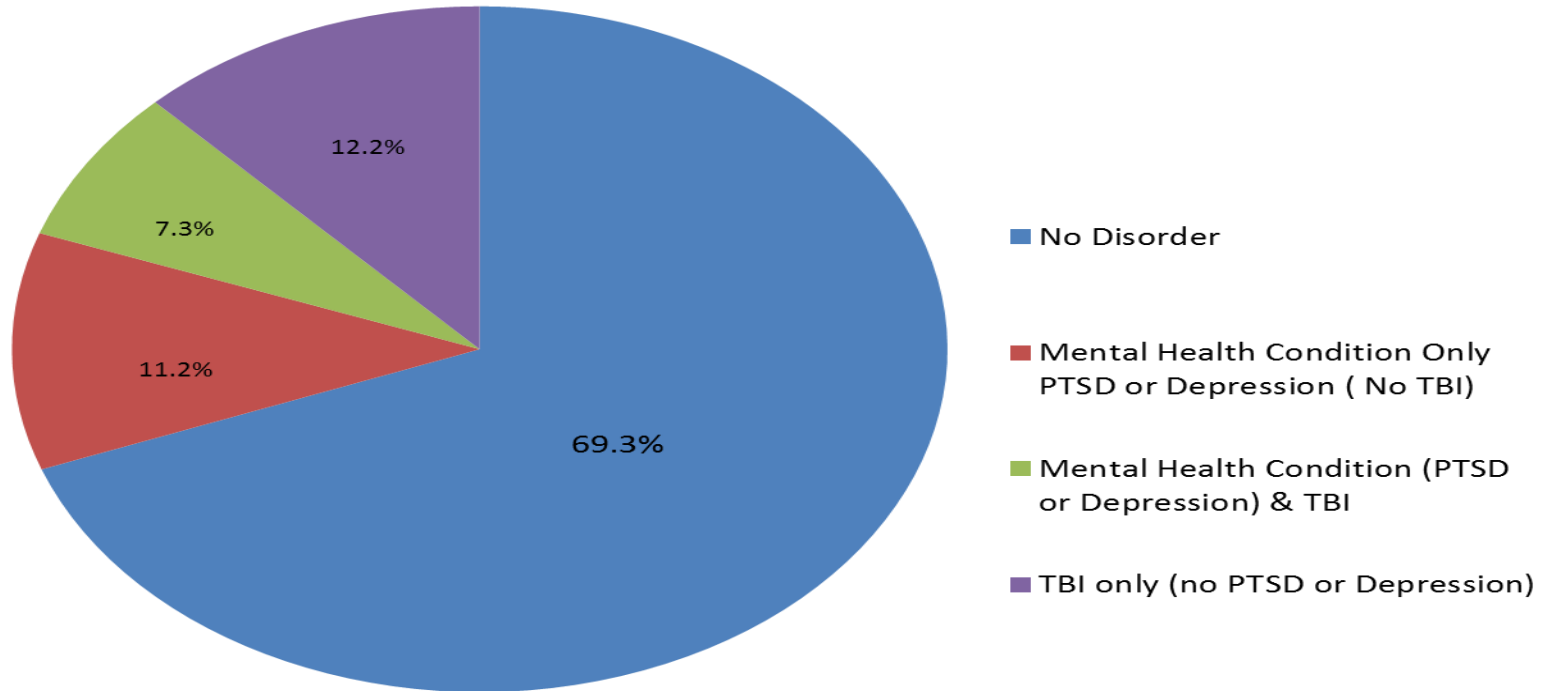
Trauma Exposures Reported by OEF/OIF* Service Members



*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.”

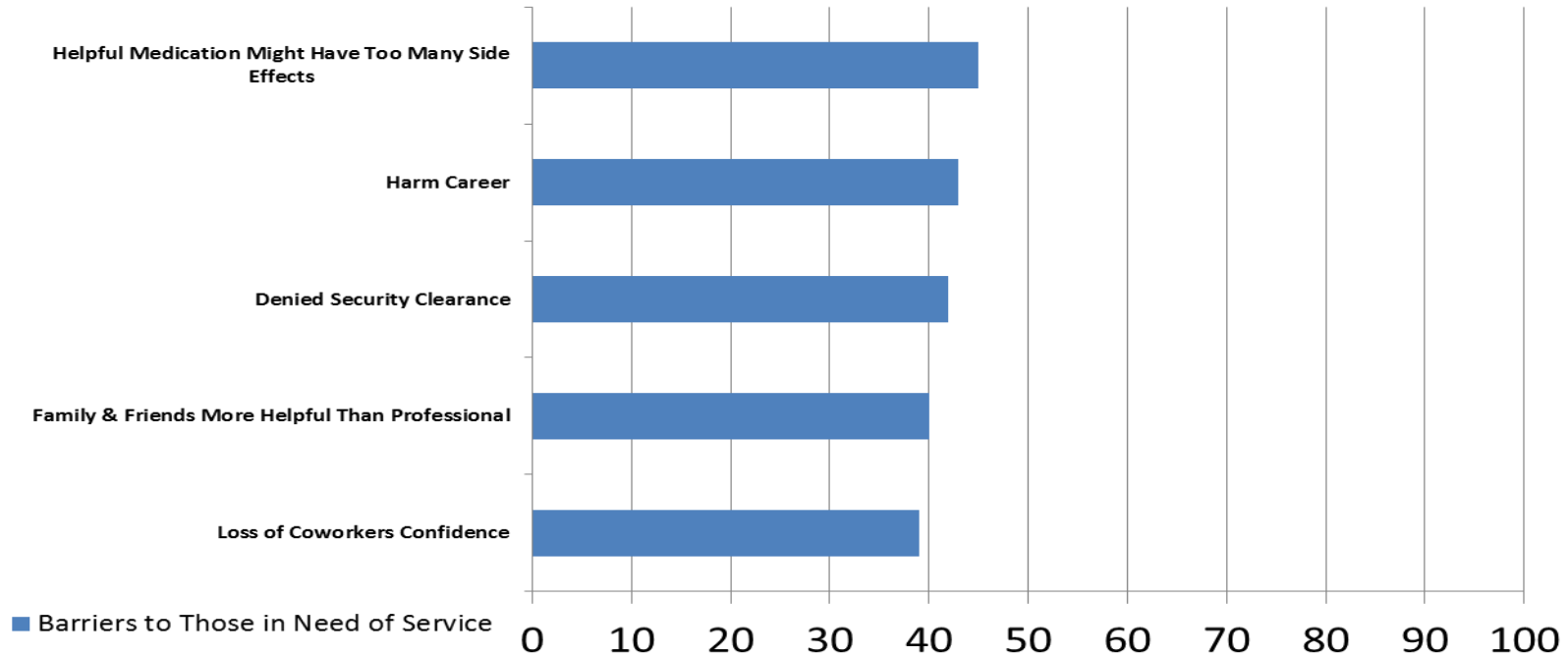
Bessel van der Kolk (2014)

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

Top Five Barriers to Care Reported Among Those with Possible Need For Services (N=752)



Invisible Wounds of War-2008 Rand Corporation Monograph

INTERVENTIONS

1. “For adults and children, almost all therapeutic approaches to PTSD incorporate some review and reprocessing of traumatic events” (Pynoos, 1990).
2. “Central to virtually all treatment strategies is an emphasis on re-exposing the individual to the traumatic cues in a structured and supportive manner” (Lyons, 1987).
3. Exposure is the key therapeutic ingredient (Silverman & Kurtines 2001).
4. Re-exposure can take place in a gradual manner as in desensitization procedures or in massive doses as in exposure and flooding therapies.
5. Anxiety management training & EMDR (eye movement desensitization and reprocessing) might also be used
6. Social/vocational/academic reintegration must also be emphasized.

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

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

➤ **Safety**

➤ **Trustworthiness/
Transparency**

➤ **Peer Support**

➤ **Collaboration/Mutuality**

➤ **Empowerment, Voice, &
Choice**

➤ **Cultural, Historical &
Gender Issues**

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

Post-Traumatic Reactions:

Goal is establishing an atmosphere of calm and safety....Avoid Escalation of PTSD Reaction

Essential Strategies

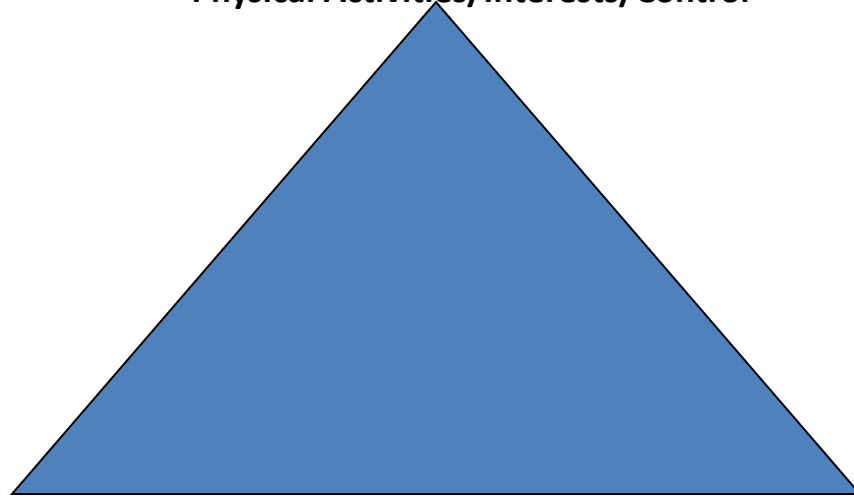
- Quality Medical Management
- Optimal Interpersonal Management
- Proactive Environmental Accommodations

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' needsdirect 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

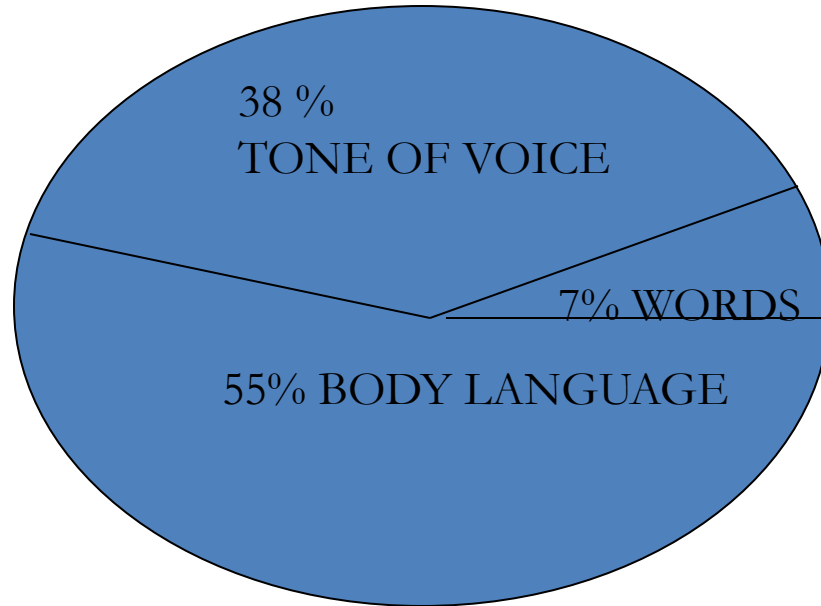
Big actions are not as polished as...

Small actions,

Small actions are not as polished as

Stillness

Three Ingredients of Good Communication



Minimizing Triggers

- Reassuring physical gestures are helpful, but avoid excessive physical contact
- Communicate with residents in areas with minimal distractions

Minimizing Triggers

- Keep daily care predictable..promote routine and structure...resident is reactive to your interpersonal style and environment
- Remain Positive to Neutral in your interactions..if the resident is going to be calm... you have to model calm behavior
- Identify resident's comfort zone..activities, best time, preferences
- Look for environmental triggers that elicit PTSD Reactions...talk to the resident...remember PTSD reactions are conditioned...not rational.

- Don't personalize insults, accusations, or threats, but don't ignore them
- Set limits, but do so in a calm/professional manner. Be positive when you can and in the worst case be neutral...avoid over responding...it only escalates situation
- Avoid making interactions a struggle for control
- Avoid contaminating the atmosphere around resident care
- Establish realistic expectations of resident

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

Summary & Questions

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