TRAUMA INFORMED SOCIAL WORK PRACTICE

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AGENDA

- History of trauma
- What is trauma?
- The Neurobiology of Trauma
- Dissociation
- Developmental Trauma / complex trauma
- Attachment theory
- Trauma informed Social Work practice
- Self Care and trauma
- Discussion/reflections/questions........
MEDUSA IN GREEK MYTH – TURNING PEOPLE TO STONE
GREEKS

One soldier, fighting in the battle of Marathon in 490 BC, reportedly went blind after the man standing next to him was killed, even though the blinded soldier "was wounded in no part of his body."

Also, Herodotus records that the Spartan leader Leonidas dismissed his men from combat because he realized they were mentally exhausted from too much fighting.
Some experts think the Iliad is describing PTSD when Homer says Ajax went mad under Athena's spell, slaughtering a herd of sheep that he thought were the enemy, and then killing himself.

Samuel Pepys describes his trauma after the Great Fire of London 1666, which left him with "dreams of the fire and the falling down of houses." He had a hard time sleeping due to his "great terrors of fire," and actually considered suicide.

“Irritable heart” / “soldiers heart” described for the first time in the American civil war 1861
World War I researcher, Millais Culpin, described dissociative states that were linked to extreme terror. When he asked a soldier to close his eyes and describe his first experience of fighting, he "seemed to be living his experience over again with more than hallucinatory vividness, ducking as shells came over or trembling as he took refuge from them."
- Combat exhaustion – world war II
- Stress response syndrome – Vietnam war
- DSM II
- 1980 – DSM III - PTSD
WHAT DO WE MEAN BY TRAUMA

- A traumatic event involves a single experience, or enduring repeated or multiple experiences, that completely overwhelms the individual’s ability to cope or integrate the ideas and emotions involved in that experience.
Regardless of its source, trauma contains 3 common elements:

- It was unexpected
- The person was unprepared
- There was nothing the person could do to stop it from happening

“trauma is when we have encountered an out of control, frightening experience that has disconnected us from all sense of resourcefulness or safety or coping or love”

- Tara Brach, 2011
Neuroscientists over the last few decades have discovered how trauma and fear affect the brain, especially the impact of experiences on child neurodevelopment.

The brain adjusts to patterned-repetitive experiences that are understood through our senses.

Nurturing environments result in healthy growth, while traumatic experiences result in unhealthy neurodevelopment.
Healthy Brain
This PET scan of the brain of a normal child shows regions of high (red) and low (blue) activity. At birth, only primitive structures such as the brain stem (center) are fully functional; in regions like the temporal lobes (top), early childhood experiences shape the circuits.

An Abused Brain
This PET scan of the brain of a Romanian orphan, who was institutionalized shortly after birth, shows the effect of extreme deprivation in infancy. The temporal lobes (top), which regulate emotions and receive input from the senses, are nearly quiescent. Such children suffer emotional and cognitive problems.
Human Brain

Brain Structures Involved in Dealing with Fear and Stress
The limbic system is primed to remain alert. With an alarm system stuck on “high” people impacted by trauma startle easier, have trouble accurately reading faces and social cues, have difficulty sleeping, and tend to avoid situations that increase stress.

These individuals may appear aggressive, as they might be overly sensitive to perceived threats (words or gestures from peers) or withdrawn due to fear of being close to others.
The hippocampus, which is a part of the limbic system and is involved in organizing memories, is actually smaller in people who have experienced long-term trauma.

Cortisol causes cell death in the hippocampus. Problem solving can then be difficult (Badenoch, 2008)

“It is hard to be aware of moments of wellbeing. All the good things slide out of awareness” (Hanson, 2009)
Traumatized children aren't able to concentrate in school. They have difficulty learning how to interact socially, because they're in flight, fight or freeze mode.

They may grow up using substances that offer relief from their situation, or to keep a door closed on the past. And the more types of trauma they experienced -- the higher their ACE score (adverse childhood experiences) -- the more likely the addictive behavior.
WINDOW OF TOLERANCE
Window of Tolerance

Hyperarousal Zone

↑

Window of Tolerance

Optimal Arousal Zone

↓

Hypoarousal Zone

2. Sympathetic “Fight or Flight” Response
   - Increased sensations, flooded
   - Emotional reactivity, hypervigilant
   - Intrusive imagery, flashbacks
   - Disorganised cognitive processing

1. Ventral Vagal “Social Engagement” Response
   - State where emotions can be tolerated and information integrated

3. Dorsal Vagal “Immobilisation” Response
   - Relative absence of sensation
   - Numbing of emotions
   - Disabled cognitive processing
   - Reduced physical movement

Adapted from Ogden, Minton, & Pain, 2006, p. 27, 32; Corrigan, Fisher, & Nutt, 2010, p. 2
TRAUMATIC STRESS SYMPTOMS

- Psychomotor agitation
- Amnesia
- Somatic symptoms
  - Chronic pain
  - Numbing
  - Intrusive memories
  - Nightmares
  - Hyper-arousal
- Insomnia
- Irritability
- Anxiety/Panic
- Rage
- Self destructive behaviour
- Flashbacks
- Grief Reactions
- Hopelessness
- Decreased interest
- Decreased concentration
- Hypo-arousal
- Substance abuse
SIGNS OF ACTIVATION - HYPER AROUSAL

- Agitation
- Flushing
- Sweating
- Tension
- Dilated pupils
- Rapid frenzied behaviour
- Fast shallow breathing
- Digestive issues
- Extreme affect/enraged/hysterical
Dissociation (Hypoarousal)

- Not everyone responds to trauma in classic “fight or flight”. Some people’s limbic system “shuts down”. People freeze, become numb and dissociative, and may actually faint in the midst of a serious crisis (Porges, 2012)

- An unconscious application of an ancient survival mechanism “playing dead”. Losing consciousness is an extreme end of the freeze response. More often people bounce between hypervigilance and dissociation (Van der Kolt, 2012)
**Dissociation – what do you need to know?**

- Dissociation is an experience of being disconnected from feelings, feeling numb, dead or shut down.
- We all have the ability to dissociate
- When dissociation is connected with a traumatic experience, clients can experience a complete shutdown of sensory experience. Clients describe living in a fog most of the time, or barely existing, being completely detached from feelings

- Clients who dissociate may have difficulty with sensory awareness, or their perceptions of senses might change. Familiar things might start to feel unfamiliar, or the client may experience an altered sense of reality (derealisation)
Dissociation – how to spot

A form of hypoarousal – Look out for cues –
- If the client feels in a fog
- The client consistently asks the therapist to repeat the question
- The client feels as though they are a long way away
- The client cannot hear your voice, or you sound faint
- The client loses time, or cannot remember previous session
- The client cannot tell what is real
- The client feels empty or ‘nothing’
**Dissociation – How to Spot**

- What happens in ourselves?
- Our mind goes blank
- Feeling dizzy, spacey
- We pull away
- Feeling disconnected
- Feeling sleepy with a client
- Feeling confused
- Feeling numb
- Feeling bored with client
- Feeling like the client has gone somewhere else
- A sense of chaos
- Things don’t add up
ATTACHMENT AND EARLY CHILDHOOD DEVELOPMENT

- We know from neuroscience research that consistent, responsive, emotionally attuned caregiving in the early years facilitates neural growth and development in the brain and provides young children with the neurological capacity to self-soothe (Perry & Szalavitz).
ATTACHMENT

- A highly adaptive way to survive
TRAUMA INFORMED CARE

Rather regardless of their primary mission, to delivery primary care, mental health, housing etc...their commitment is to provide services in a manner that is welcoming and appropriate to the special needs of those affected by trauma (Harris & Fallot, 2001).
GROUNDING

• Connects us to our bodies

• Without which we cannot be aware of what is happening inside us

• Creates a sense of SAFETY

• Brings us back to the here and now
TRAUMA INFORMED CARE – WHAT IS IT IN PRACTICE

- Regardless of its mandate, every system and organization is impacted by trauma and will benefit from being trauma-informed.

- Every system and organisation has the potential to retraumatize people and interfere with recovery, and to support healing.

- People affected by trauma from abusive relationships will frequently encounter services that mirror the power and control they experienced in those relationships.
Core trauma informed principles are:

- Acknowledgement – recognizing that trauma is pervasive
- Safety
- Trust
- Choice and control
- Compassion
- Collaboration
- Strengths-based
At its core, the trauma-informed model replaces the labelling of clients or patients as being “sick”, resistant or uncooperative with that of being affected by an “injury”. Viewing Trauma as an injury shifts the conversation from asking “what is wrong with you” to “what has happened to you”? 
DEVELOPING YOUR PRESENCE

- Regardless of interventions used, the client-social work relationship is the base of the container.
- Trust is vital for that containing.
- You have to ‘show up’, they need you to be present, attentive, and attuned for good work to occur.
- Staying within boundaries – what is your role, what are your limitations, safe practice.
- Authentic – genuine presence
SOCIAL WORK - THERAPEUTIC INPUT

- Trauma informed practice – whether.. it is a task centred referral or counselling for domestic violence etc...
- Recognising if the client is “activated” – understanding what is happening in the body / brain in our client centred, solutions focused strengths based counselling work
- Psychoeducate on stress / trauma continuum
- Grounding/mindfulness/orientation – incorporating these skills in sessions and with yourself as social worker
- Psychosocial intervention to increase empowerment/self compassion
- Assessment based on strengths/resources
SOCIAL WORK THERAPEUTIC INPUT

- Social model – theories – system
- Loss in motherhood/anger/grief/adjustment/relationship issues/early childhood attachments/changes in beliefs
- Accessing supports/working with partner/extended family for supports
- Name it in teams /colleagues - “this may be a trauma response”...and highlight impact of same
- “stabilisation of environment” crucial for trauma working – homelessness e.g
- Inpatients – involuntary admissions
SELF CARE AND WELLNESS

- Attending to our own wellness is important because it plays a significant role in our ability to attune to our clients in a meaningful and engaged way.
- Comfortable with the unknown –
- Willingness to connect emotionally to experience of client’s trauma
- Supervision –
- Consider group supervision in your agency?
- What is happening? What am I feeling? How might that be information about my client/or me? What theory can help me make sense of this.
- Impact of trauma / trauma exposure response
**TRAUMA EXPOSURE RESPONSE**

- A service user may experience one or two or even more of the following –
- Feeling hopeless or helpless
- A sense that one can never do enough
- Hyper vigilance
- Diminished creativity
- Inability to embrace complexity (black and white, right and wrong, “us” and “them” thinking
- Minimizing
- Chronic exhaustion/physical ailments
- Inability to listen/deliberate avoidance
TRAUMA EXPOSURE RESPONSES

- Guilt
- Fear
- Anger and cynicism (negative thinking)
- Inability to empathize
- Addictions
- Grandiosity

Service providers bring their own trauma histories to their work. What we know is that this increases risk of further traumatisation. It is essential that providers recognise and acknowledge their own histories.
And finally...

Breathe....

Thank you!

QUESTIONS/ REFLECTIONS