



Wisconsin Public Psychiatry Network Teleconference (WPPNT)

Department of Health Services (DHS) Bureau of Prevention, Treatment and Recovery and the University of Wisconsin-Madison, Department of Psychiatry.

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Part 2- Adopting Trauma-Informed Care

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Learning Objectives

- 1 Define secondary traumatic stress, compassion fatigue, and burnout and its effect on organizational resilience
- 2 Gain a greater understanding of staff's level of compassion satisfaction, compassion fatigue, and burnout
- 3 Begin to examine the communication processes we presently employ and begin to adopt recovery-based language

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Why Trauma-Informed Care?

"We are a traumatized field working with traumatized clients, sending them to a traumatized recovery community."
- Dan Griffin

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Trauma-Informed Care (TIC)

TIC is:

- o An intervention and organizational approach.
- o A focus on how trauma may affect an individual's life and their response to behavioral health services.
- o A movement from "What's wrong with you?" to "What happened to you?"

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Trauma-Informed Care (TIC)

TIC:

- o Is a way of being
- o Is understanding what people are going through
- o Is a way of talking
- o Is a way of offering care

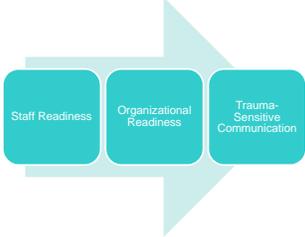
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Staff Readiness



The first step in the journey to become trauma-informed is to determine how ready your staff is to adopt TIC.



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Empathy



“What is to give light must endure burning.”
- Viktor Frankl

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Staff



- As helpers, we bring ourselves and our experiences to work every day
- Helpers are not just those with a clinical background
- That which makes us so effective in the service of others can also hurt us

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Staff



- To be able to deliver services in a trauma-informed way, it is necessary to take stock of ourselves
- The impact of prior exposure to trauma can not be discounted
- Secondary traumatic stress (STS), compassion fatigue (CF), and burnout are common

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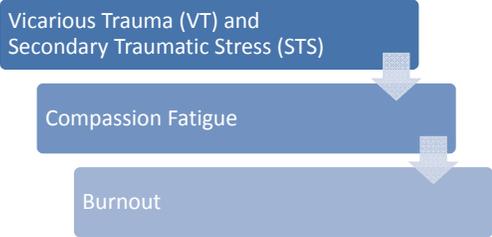
How Have You Changed?



- How has my work changed me personally?
- How has my work changed me professionally?

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Downward Spiral

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Vicarious Trauma and Secondary Traumatic Stress



- It is work-related, secondary exposure to extremely or traumatically stressful events
- It is often the result of the exposure of helpers to experiences of clients, in tandem with empathy experienced for clients (Collins and Long, 2003)
- It can be sudden and acute (Adolescent Health Working Group, 2013)

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Vicarious Trauma and Secondary Traumatic Stress



- It is anything that interferes with the helper's ability to fulfill his or her responsibility to assist traumatized clients can contribute to STS (Pryce et al., 2007)
- It can result in a transformation in the helper's inner experience (Pearlman and Mac Ian, 1995)

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Compassion Fatigue



- Deep physical, emotional, and spiritual exhaustion accompanied by acute emotional pain
- Practitioners continue to give themselves fully to their clients
- Great difficulty in maintaining a healthy balance of empathy and objectivity (Leiter and Maslach, 1998)

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Burnout



- It is a syndrome of emotional exhaustion and depersonalization
- It reduces the sense of personal accomplishment
- It is a loss of empathy (Leiter and Maslach, 1988)
- It results in feelings of hopelessness
- It creates difficulties in doing one's job effectively (Stamm, 2010)

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Impact On Staff



Secondary traumatic stress and compassion fatigue impact on your staff in the following ways:

- Cognitively
- Socially
- Emotionally
- Physically

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Impact On Staff



Cognitive	Social	Emotional	Physical
Negative bias (judging and labeling)	Reduced collaboration	Helplessness	Headaches
Pessimism	Withdrawal	Hopelessness	Tense muscles
Loss of perspective	Easily angered	Overwhelmed	Fatigue
Decreased self-monitoring	Difficulty trusting	Depressed, worried	Lowered immune system
Intrusive thoughts	Avoidance	Numb-shutting down	
Black and white thinking	Isolation	Hyper vigilant	

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(Administration for Children's Services - New York University Children's Trauma Institute)
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ProQOL: Professional Quality of Life Scale

- It is free
- It contains a 30 item self report measure of the positive and negative aspects of caring
- It measures compassion satisfaction and compassion fatigue
- It has two subscales, burnout and secondary trauma

(Copyright Beth Hudnall Stamm, 2009, www.ProQOL.org)

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ProQOL: Professional Quality of Life Scale

- It is the most widely used measure of the positive and negative aspects of helping in the world
- It has been proven to be a valid measure of compassion satisfaction and fatigue
- It has been used for over 15 years
- It was developed with data from over 3,000 people

(Copyright Beth Hudnall Stamm, 2009, www.ProQOL.org)

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ProQOL: Professional Quality of Life Scale

- It helps us understand the positive and negative aspects of helping
- It is not a psychological test
- It is not a medical test
- It can be viewed as a screening for stress-related health problems

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ProQOL: Professional Quality of Life Scale

- It is easy to score
- It contains full scoring:
 - More detailed and specific information but takes longer
 - Better for research or administration
- It contains simplified scoring:
 - Less specific but can be completed quickly
 - Good for training situations

(Beth Hudnall Stamm, 2009, www.ProQOL.org)

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Organizational Readiness

The next step in the journey to become trauma-informed is to determine how ready your organization is to adopt TIC.

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System Level Impact

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System Level Impact

Organizations create a social context with risk factors that could increase the likelihood of STS reactions such as:

- o Lack of resources for consumers
- o Lack of clinical supervision
- o Lack of support from colleagues
- o Lack of acknowledgement by the organizational culture that STS exists and that it is a normal reaction to client's trauma

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Mitigating the impact of STS and CF

- Mixing caseloads
- Supporting ongoing counselor training
- Regular supervision (reflective supervision)
- Recognizing staff's efforts
- Offering empowering work environments
- Bring in outside activities

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Trauma-Sensitive Communication

The final step in the journey to adopt trauma-informed care is to adopt trauma-sensitive communication.



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Importance of Communication

- No organization can transition to one that is trauma-informed, trauma-responsive until the organization's communication style moves from deficit-based language to one that is strength-based
- Old communication patterns and habits need to be challenged

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Trauma-Sensitive Communication

Rosenberg's Compassionate Communication Model is trauma-sensitive empathic listening and communication model consisting of four steps:

- o Making observations without judging
- o Identify feelings (comes from the need)
- o Identify needs (around the situation)
- o Make a request (without demands) to get needs met

(Marshall Rosenberg, crvc.org)

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Trauma-Sensitive Communication

- Empathy equals the ability to connect feelings and needs
- Congruency between verbal and non-verbal communication is vital
- Ask yourself: "Do I want to enter a boxing ring or a dance floor?"

(Based on Marshall Rosenberg, crvc.org)

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Principles of Dialog

- Use of authentic voice
- Congruency between verbal and non-verbal communication
- Listen to hear. Partner without resistance; let go of the need to be right
- Identify and suspend certainty about own beliefs or views (judgments)

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Principles of Dialog (cont'd)

- Be affected by each other's emotions (connect on feeling/needs level)
- Respect the whole person:
 - Respect the other
 - Respect the differences
 - Hold a space of good will

(Based on Jean Clement, APNA-RTP, 2014)

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Empathic Listening

- Listen to hear the observations, feelings, needs, and requests
- Avoid advice-giving, judging, or fixing
- Behind judgments are unmet needs

(Marshall Rosenberg, Ph.D., Nonviolent Communication: A Language of Life, 2003, crvc.org)

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Empathic Listening

- Paraphrase back emotionally charged statements
- Empathy has been received when there is a release of tension and the flow of words comes to a halt

(Marshall Rosenberg, Ph.D., Nonviolent Communication: A Language of Life, 2003, crvc.org)

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Trauma-Sensitive Skills Practice

- Think about a situation (work or home)-not too personal
- Make an **observation** without judgments
- What are you telling yourself (thinking) about the observation? (Recognize and acknowledge judgments)
- Identify your **feelings** (convert judgments to empathy)
- Identify your **needs** (convert judgments to empathy)
- Make a request without demands that will get my need met

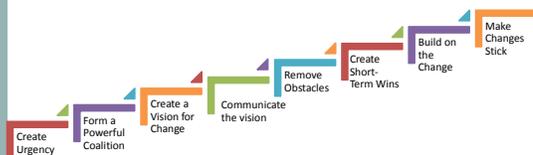
(Based on the Marshall Rosenberg Compassionate Communication Model, crvc.org)

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John Kotter: Eight Stages of Change



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Step 1: Create Urgency

- Identify potential threats and develop scenarios showing what could happen in the future.
- Examine opportunities that should be or could be, exploited.
- Start honest discussions-give dynamic and convincing reasons to gets people talking.
- Request support from consumers, outside stakeholders to strengthen your argument.



Step 2: Form a Powerful Coalition

- Identify true leaders in organization, as well as key stakeholders. These are your TIC champions
- Ask for emotional commitment from these people
- Work on team building within your change coalition
- Check your team for weak areas. You need a good mix of people



Step 3: Create a Vision for Change

- Determine the values that are central to the change.
- Develop short summary (one to two sentences) that captures what you “see” as the future for the organization.
- Create a strategy to execute the vision.
- Ensure your change coalition can describe the vision in five minutes or less.
- Practice your vision speech often.



Vision Statement Example

“As behavioral health service providers, we strive to be trauma-aware—to understand the dynamics and impact of trauma on the lives of individuals, families, and communities. We strive to create a trauma-sensitive culture by demonstrating, through consumer empowerment, program design, and direct care, an understanding of the relationships among trauma, substance abuse, and mental illness.”

(SAMHSA, 2014)



Step 4: Communicate the Vision

- Talk often about your change.
- Address peoples’ concerns and anxieties, openly and honestly.
- Apply your vision to all aspects of operations- from training to performance reviews. Tie **everything** back to the vision.
- Lead by example.



Step 5: Remove Obstacles

- Identify or hire change leaders whose main role is to deliver the change.
- Recognize an reward people for making the change happen.
- Identify people who are resisting the change, and help them see what’s needed.
- Take action quickly to remove barriers (human or otherwise).



Step 6: Create Short-Term Wins

- Look for sure-fire projects you can implement without help from any strong critics for the change
- Don't choose early projects that are expensive



Step 7: Build on the Change

- Don't let up!
- After every win, analyze what went right, and what needs improving
- Set goals and continue building on the momentum
- Keep ideas fresh by bringing in new TIC Champions for your coalition



Step 8: Make Changes Stick

- Talk about progress every chance you get. Tell success stories, share testimonials
- Ask: What are ways we can maintain our momentum and keep moving forward?
- Change performance expectations
- Change documentation requirements
- Use data to provide continuous feedback
- Include change ideals and values when hiring new staff



Next Steps

- Complete an organizational assessment
 - Creating Cultures of Trauma-Informed Care: Program Fidelity Scale
 - Gauge the extent to which your organization has developed a culture of trauma-informed care

(Adapted from: Roger D. Fallot and Maxine Harris. 2014. The authors gratefully acknowledge the assistance of Stephanie Covington, Eileen Russo, Colette Anderson, and Kim Selvaggi in developing and formatting this scale.)

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Measure Across All Six Domains

- Domain 1: Program procedures and settings
- Domain 2: Formal service policies
- Domain 3: Trauma screening, assessment, and service planning
- Domain 4: Administrative support for program-wide trauma-informed services
- Domain 5: Staff trauma training and education
- Domain 6: Human resource practices

(Adapted from: Roger D. Fallot and Maxine Harris. 2014.)

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