

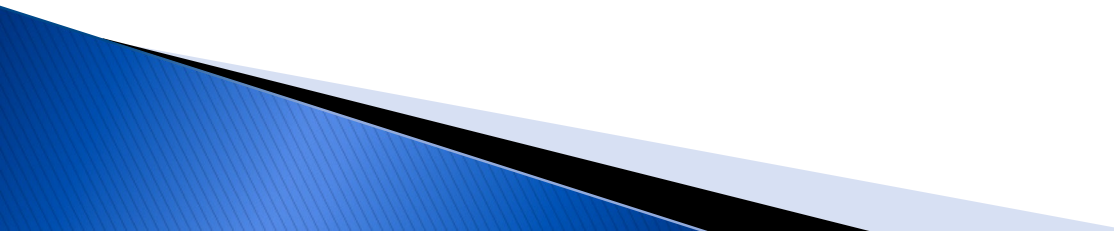
Trauma, Memory, and Trauma Informed Care for Substance Use Counseling

The Science and Practice of Trauma Informed Care
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 - Graduate of CSPP Los Angeles
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Agenda

- ▶ Explain the Role of Memory and Learning with Trauma
 - ▶ Identify Theories and Approaches for providing Trauma Informed Care
 - ▶ How to provide psycho-education about the process of trauma treatment
 - ▶ Recommendations for practice
- 

Please Note

- ▶ Because there is a lot of really important information to get to, the flow of this presentation will move through some of this information quickly
 - This does not mean it is not important information, just that there is a lot to cover
- ▶ My theory is that it is better to give you the information that you can later go back and review rather than to not include important information

More about the training



Information about
Trauma Informed Care

Information about how
to manage symptoms

Information that can be
used in a variety of
settings

Not training how to
diagnosis trauma

Not a training how to
process trauma
narratives

What is Trauma Informed Care?

»» A brief definition

Trauma

- ▶ There are many events people experience that can be considered traumatic
 - Trauma and trauma
- ▶ Not every traumatic experience results in trauma symptoms (Dass-Brailford, 2007)
- ▶ If there is the presence of symptoms related to trauma, then these can be very distressing
 - There are evidence-based approaches for how to manage trauma symptoms

(Atkins, 2014; Friedman, Keane & Resick, 2014)

The Treatment of Trauma

- ▶ When reviewing the literature there is a helpful distinction between

Treating the trauma experience directly
and

Treating the effect of the symptoms of trauma

This is important to consider because both are a part of a comprehensive treatment of trauma but they are not the same thing

(Atkins, 2014; Friedman, Keane & Resick, 2014; Dass-Brailford, 2007)

Treatment of Trauma Experience

- ▶ Many approaches that are EBP's for how to process the narrative and experience of trauma directly
- ▶ In order for this to be successful it requires time, training, and expertise on behalf of the clinician as well as the patient being at the right place holistically to process the trauma

(Atkins, 2014; Friedman, Keane & Resick, 2014; Dass-Brailford, 2007)

Tree Metaphor



Stabilize the tree before fixing the root system

Stabilization is important

- ▶ Because learning to manage symptoms related to trauma can help individuals stay engaged in treatment

And

- ▶ Not every clinician is trained in how to treat the experience of trauma directly

As well as:

- ▶ Not every patient is at an appropriate place to process trauma

Therefore:

- ▶ There was a need to develop approaches that are easier to use to help manage the symptoms of trauma without requiring trauma processing

Treatment of the effects of the Symptoms of Trauma

- ▶ Trauma symptoms can be pervasive
- ▶ Helping patients manage these symptoms can be extremely important
 - Approaches like DBT are focused on distress tolerance so that patients can manage the symptoms

(Development Service Group, 2015; Darmouth, 2015)



Why Trauma Informed Care?

- ▶ One of the highest co-occurring disorder with trauma is substance abuse disorders (Atkins, 2014; SAMSHA, 2014b; Development Service Group, 2015)
- ▶ Trauma informed care needs to be implemented at an organizational level
 - This means screening for trauma
 - Being aware of trauma symptoms
 - Have basic symptom management skills

Trauma Informed Care

- ▶ Trauma informed care is a process used to mediate the activation of symptoms associated with trauma as a means for helping clients stabilize
 - This does not mean that it is necessarily about processing trauma narratives (which should only be done in specific situations)
- ▶ It is a method of introducing coping skills for symptoms of trauma
 - ▶ (SAMHSA, 2014a)

Principles of Trauma Informed Care

»» (SAMHSA, 2014b)

Trauma Informed Care

- ▶ Promote Trauma Awareness and Understanding
 - Educating individuals who treat trauma and those who have experienced it
- ▶ Recognizing that Trauma–Related Symptoms and Behaviors Originate from Adapting to Traumatic Experiences
- ▶ View Trauma in the Context of the Client’s Environment
 - How was trauma processed and how is the person adapting?

Trauma Informed Care

- ▶ Minimize the Risk of Re-traumatization or Replicating Prior Trauma
 - This includes not processing the trauma narrative unless it is an appropriate time and setting
- ▶ Create a Safe Environment
 - Trust and psychological security
- ▶ Identify Recovery From Trauma as a Primary Goal
 - This is all part of the recovery process, and even trauma informed care without trauma processing is treating symptoms of trauma

Trauma Informed Care

- ▶ Support Control, Choice, and Autonomy
 - Empowerment
- ▶ Create Collaborative Relationships and Opportunities for Participation
- ▶ Familiarize the Client With Trauma-Informed Services

Trauma Informed Care

- ▶ Incorporate Universal Routine Screenings for Trauma
 - Organizational level
- ▶ View Trauma Through a Sociocultural Lens
 - Trauma differs between individuals
 - Sometimes referred to as Trauma vs. trauma
- ▶ Use a Strengths–Focused Perspective: Promote Resilience
 - Resilience is key for belief in continued coping

Trauma Informed Care

- ▶ Foster Trauma–Resistant Skills
 - Coping skills
- ▶ Show Organizational and Administrative Commitment to TIC
- ▶ Develop Strategies To Address Secondary Trauma and Promote Self–Care
 - Take care of the people who provide the services too
- ▶ **Provide Hope—Recovery Is Possible**

Section I: What's Happening

- »» What is going on cognitively during and after trauma

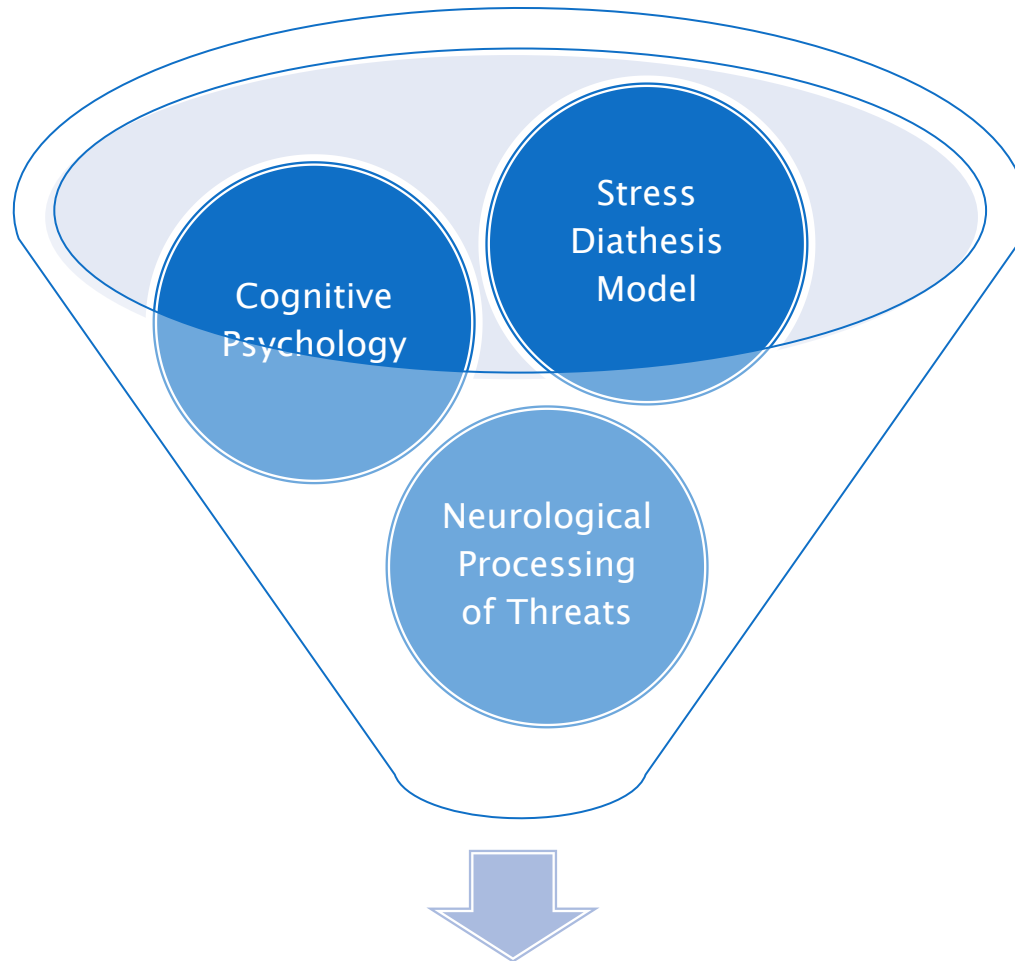
Section 1 Principles

- ▶ Promote Trauma Awareness and Understanding
- ▶ Recognize Trauma related Symptoms and Behaviors are related to adapting to a trauma experience
- ▶ Minimize the risk of re-traumatization
- ▶ View Trauma from a Sociocultural Lens
- ▶ Use a Strengths-based Perspective

Summary of this section

- Memory Uses a Neuro-network of Associations
- These associations are used in learning to protect individuals
- This is a strength-based process (including many symptoms as protectors)
- All of this information feeds into Trauma Informed Care

Setting the Frame



Theory of Trauma Processing

(Sapolsky, 2008; Anderson, 2014; van de Kolk, 2014)

How the Brain Remembers

- » Contextual understanding to symptoms

Stress Diathesis Model of Activation

- ▶ The autonomic nervous system regulates psychological activation (van der Kolk, 2014; Mahan & Ressler, 2012)
 - Cortisol, which is a stress hormone, is correlated to psychological arousal and is a good marker of stress (Sapolsky, 2008)
- ▶ Activation levels are mediated by the sympathetic and parasympathetic nervous systems (Sapolsky, 2008)

Stress

- ▶ For the purpose of this training, stress is defined as the following:
 - The recognition of the need, desire, or observation of change
- ▶ There have been attempts at defining positive stress
 - Eustress

Why Stress?

- ▶ The Hypothalamic–pituitary–adrenal axis (HPA Axis)
 - Connection of glands that are related to arousal and activation
 - (van der Kolk, 2014; LaDoux, 2002)
 - Creates a reflexive system
 - Body endocrine system influences cognition, cognition influences endocrine systems (Mahan & Ressler, 2012)

The reflexive system

- ▶ Stress levels can influence psychological processing
 - AND
- ▶ Psychological processing can influence stress levels

- ▶ This is best seen with the Autonomic Nervous System which includes both the Parasympathetic and Sympathetic Nervous Systems (Anderson, 2014)

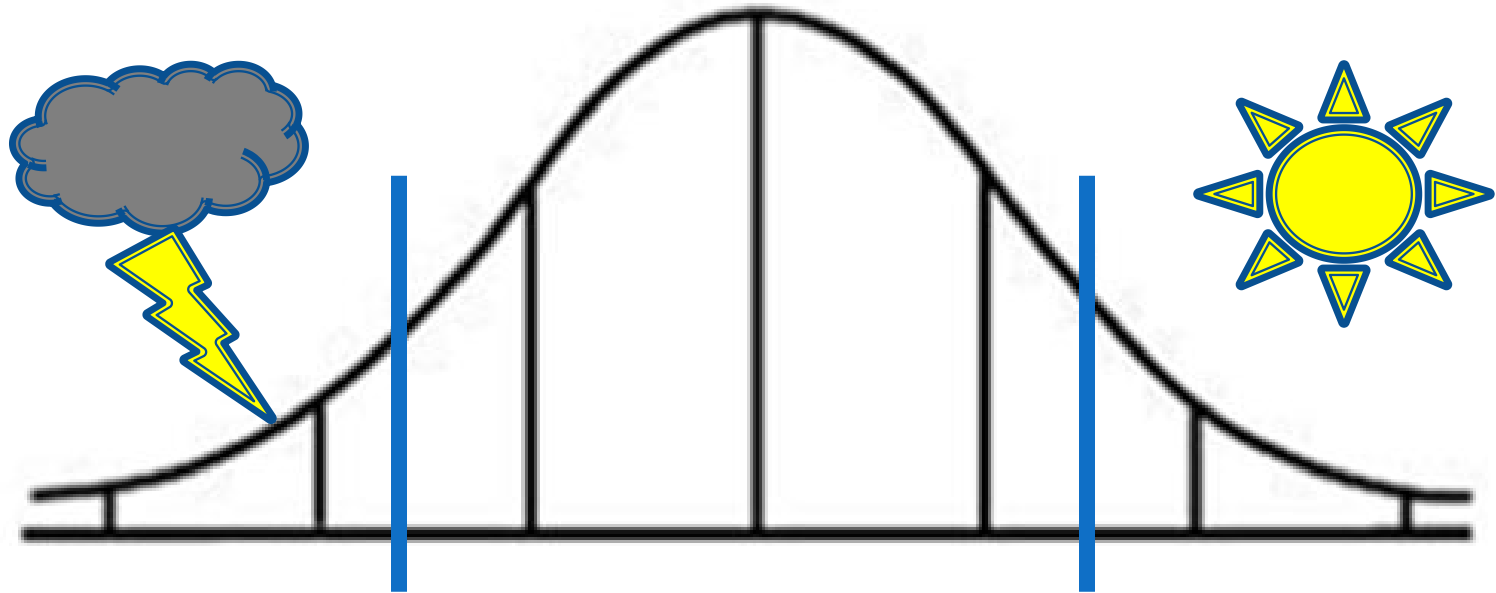
Reticular Activating System



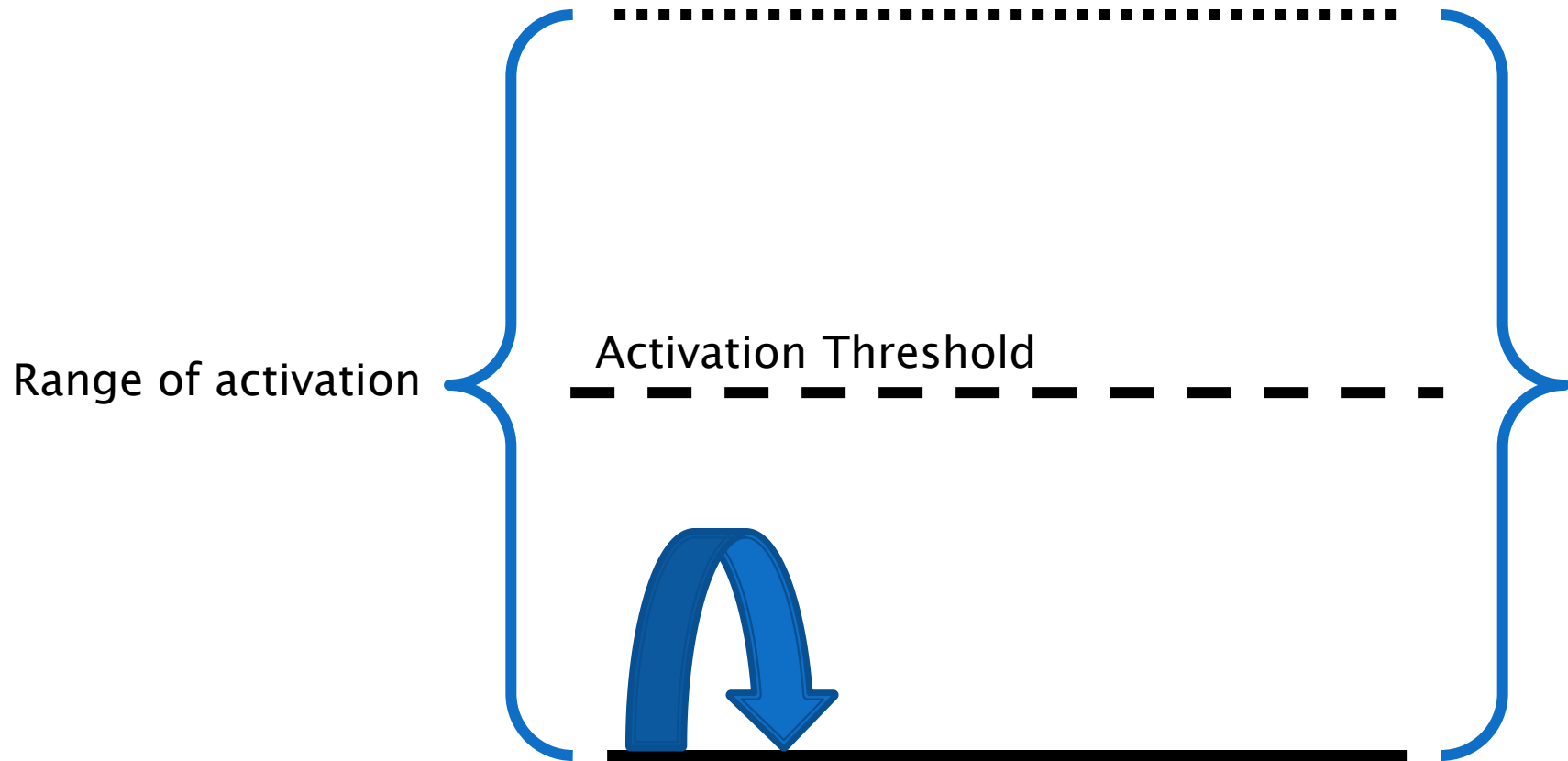
- ▶ The RAS filters out roughly 80% of all sensory data that we are confronted with
 - Otherwise we would be overwhelmed with sensory information and would not be able to function effectively

- (Anderson, 2014)

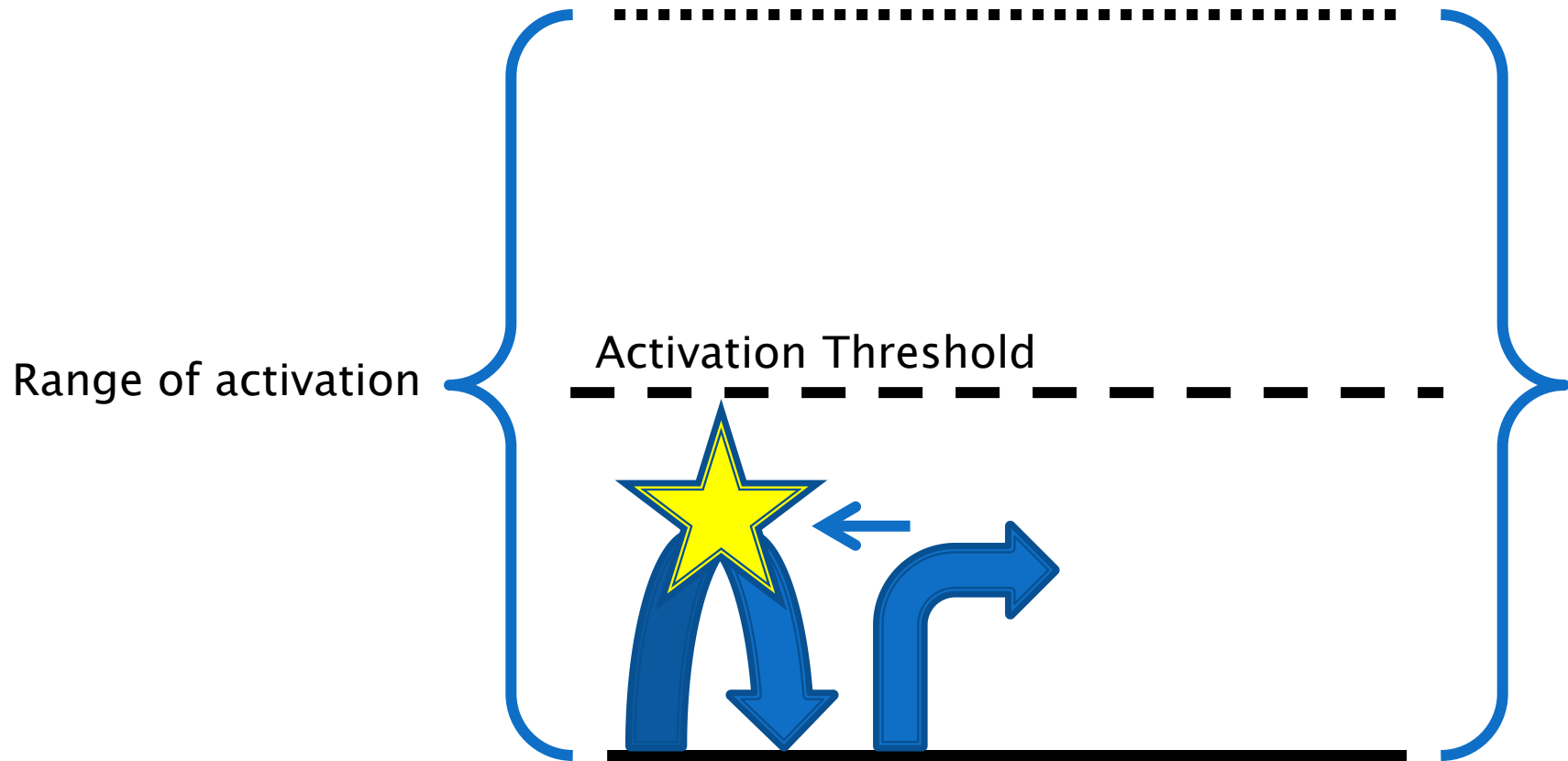
RAS Processing



Normal responses to everyday stressors

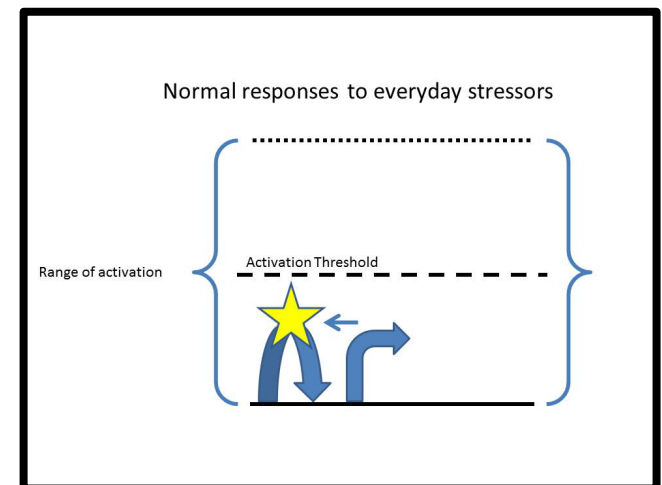


Normal responses to everyday stressors



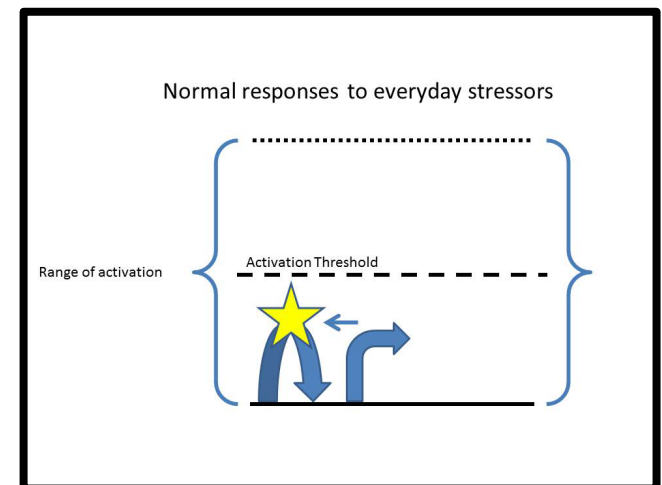
Stressors can help with learning

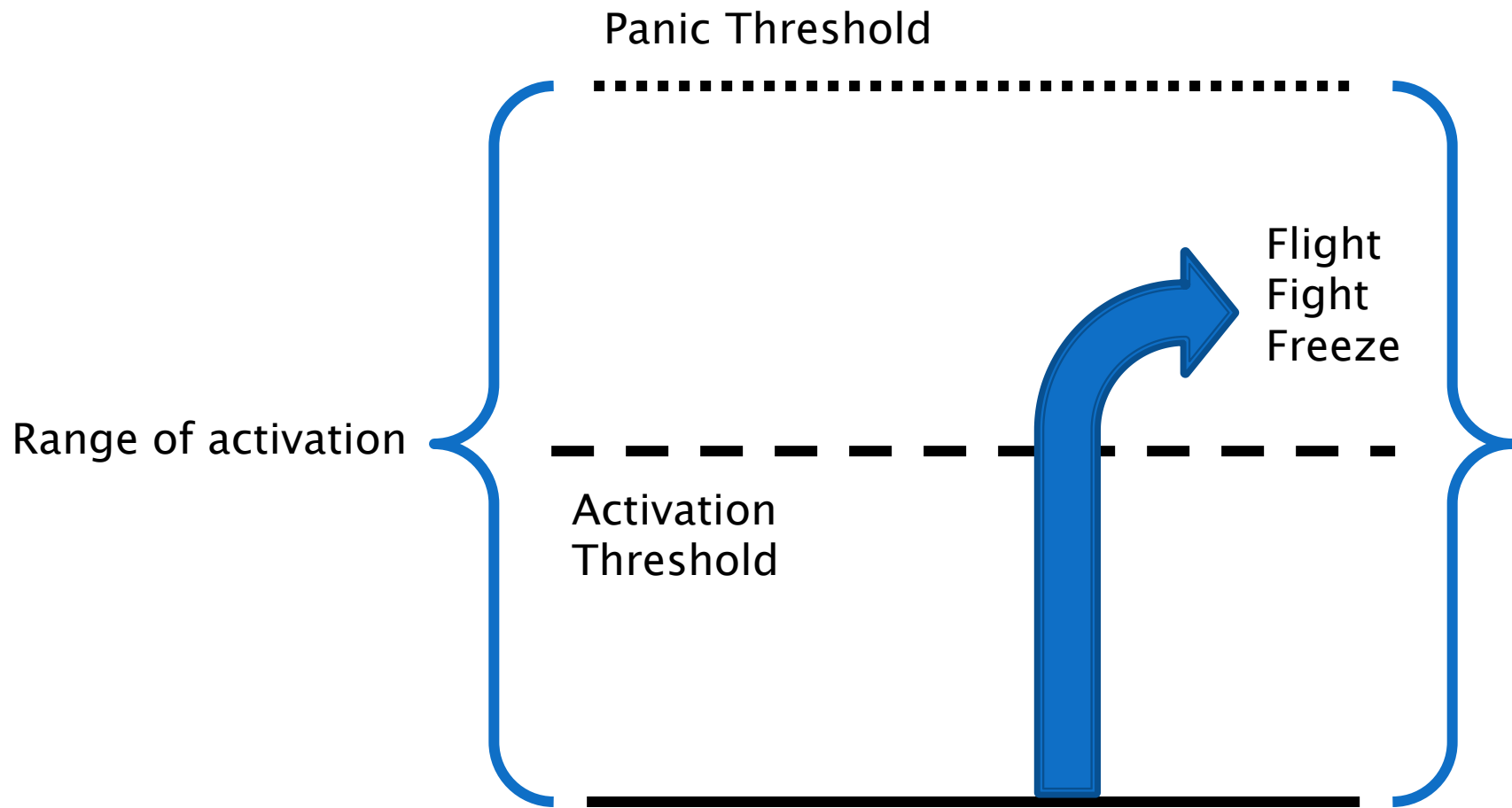
- ▶ Trait State Memory (Anderson, 2014)
 - Memories encoded at various levels of activation (emotion states) are easier to recall once a person returns to that same level of activation (emotion) (Pankseep & Biven, 2012)



Stressors can help with learning

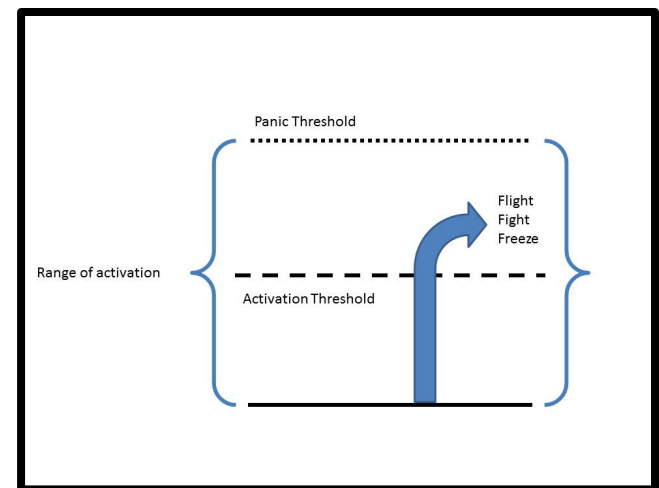
- ▶ Trait State Memory (Anderson, 2014)
 - Memories encoded in specific areas/locations are easier to recall in that same location/area





Stressors and the Amygdala

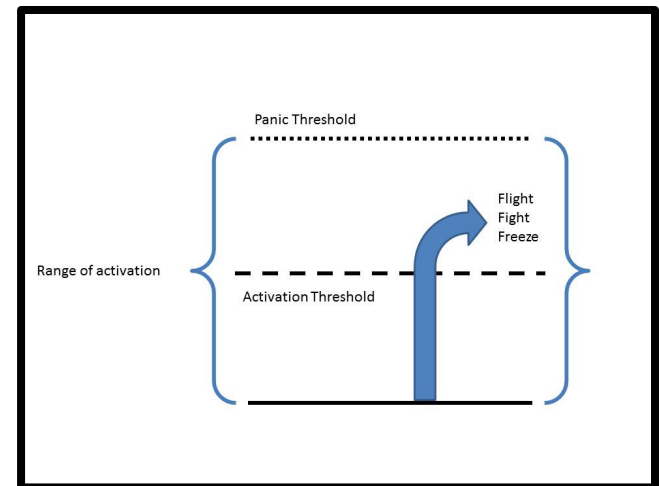
- ▶ The Amygdala helps to determine whether there is a threat to which the person should respond (Mahan & Ressler, 2012)
 - If the stress levels rise above the activation threshold, then the body goes into flight, fight, or freeze responses
 - These are survival instincts (Sapolsky, 2008)

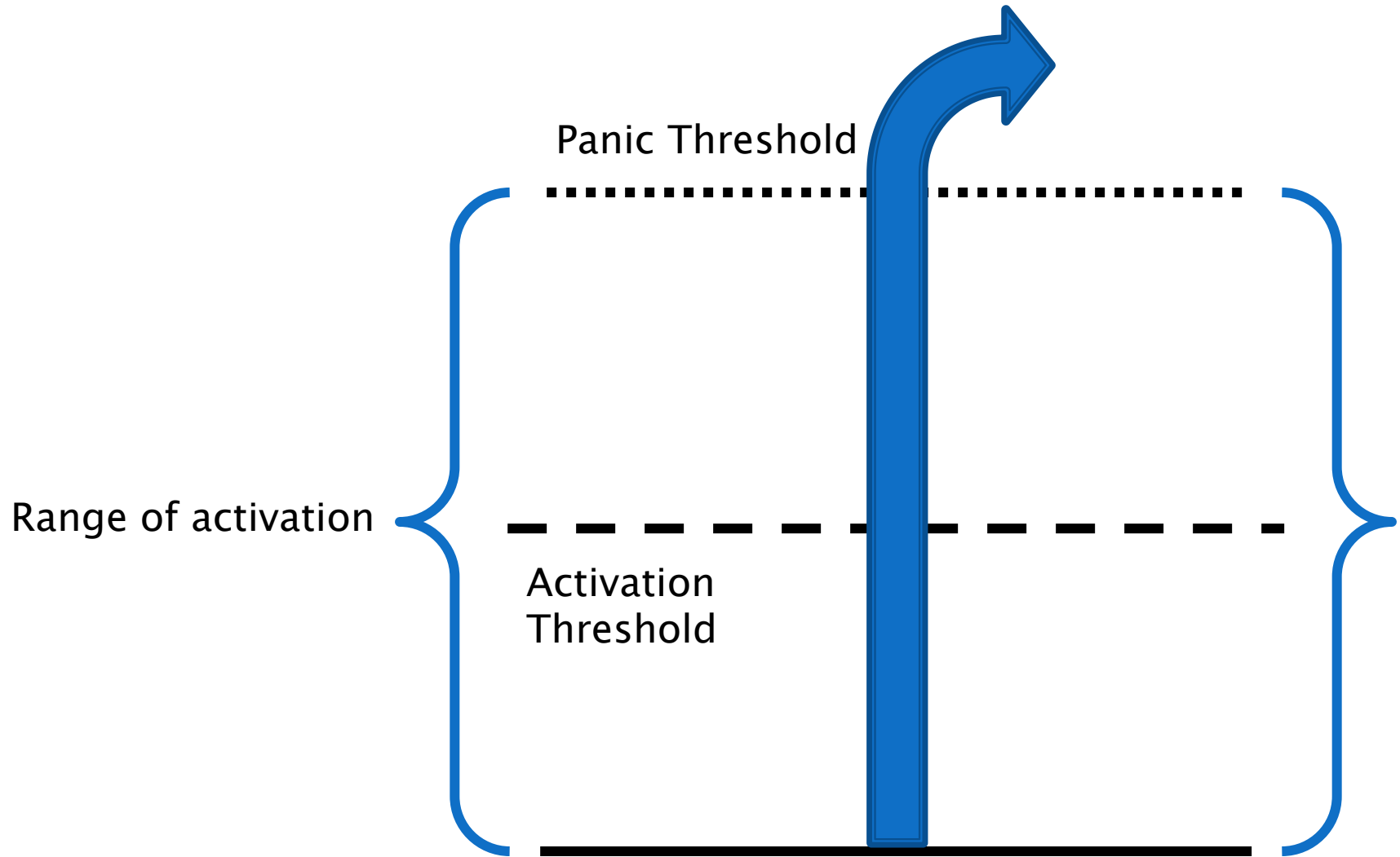


Activation Threshold

- ▶ Long-term functioning in the activation threshold level can result in symptoms that resemble
 - Anxiety (flight, sometimes fight)
 - Depression (freeze and fight)

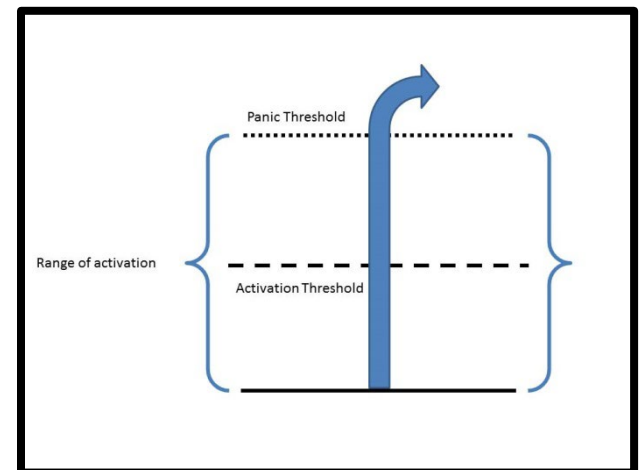
(Van der Kolk, 2014;
Sapolsky, 2008)





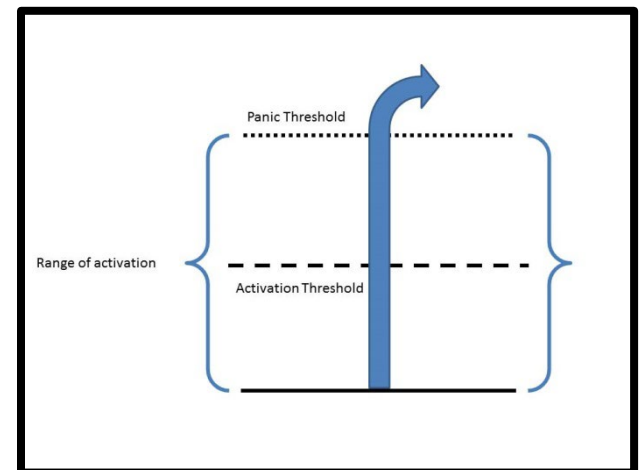
Panic Threshold

- ▶ Goal becomes – never get back to this situation again



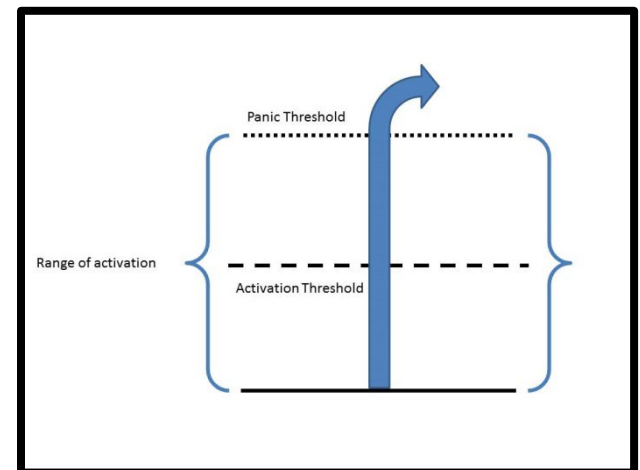
Learning Theory

- ▶ One time learning (pain)
 - ▶ Short-term learning (fear)
 - ▶ Cause and effect – processing
 - The brain often uses temporal processing to learn
 - (This is why classic conditioning works)
- (Anderson, 2014)



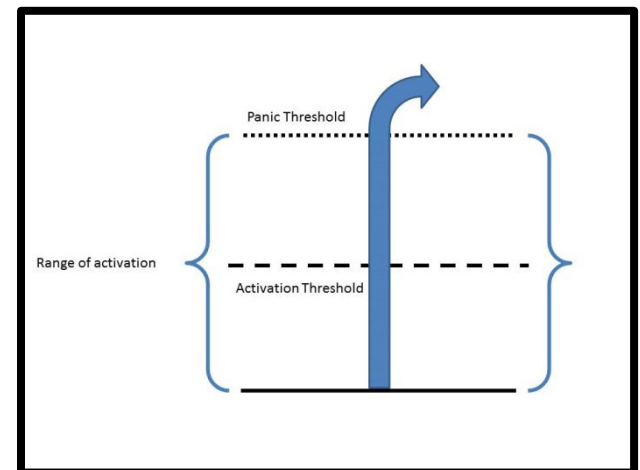
Panic Threshold

- ▶ Goal becomes – never get back to this situation again
 - To do that, the brain creates a ‘flash–bulb’ memory (Anderson, 2014; LaDoux, 2002)
 - A flash–bulb memory is a very detailed memory of a specific event, typically created under distress, that becomes easily accessible for recall



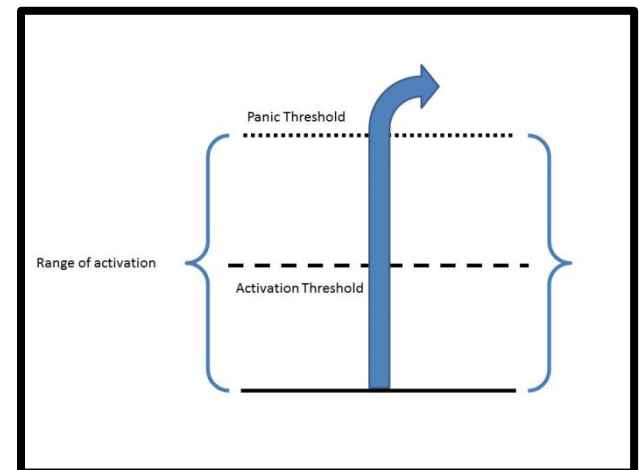
Function of the Flashbulb Memory

- ▶ Underlying theory – all events have predictors and if the brain can recognize predictors then it can avoid future trauma (van der Kolk, 2014)
- ▶ Remembering details can help identify the predictor



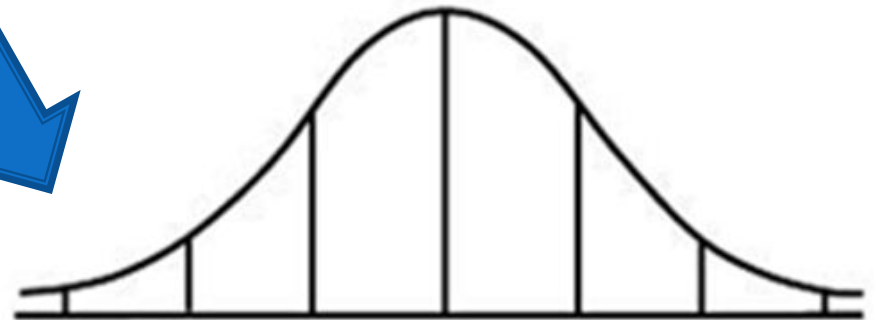
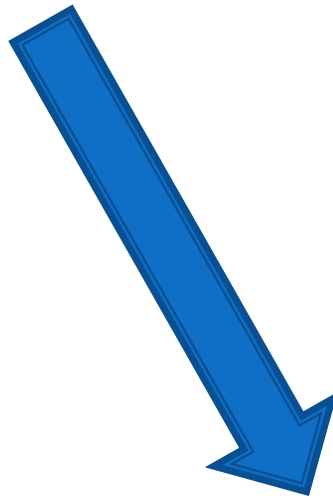
Web of Associations

- ▶ Content of the Flashbulb memory includes all data – even the types that are normally filtered out by the RAS or Reticular Activating System (van der Kaulk, 2014; LaDoux, 2002)
- ▶ Example



Flashbulb Example

Number of people in the room	Number of chairs
Temperature of the room	What I ate last
What people said recently	What I am wearing
Time that the event happened	Noises in the room
The feel of my clothing	Smells in the room

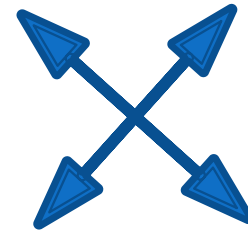


Contrast Associations

- ▶ The brain then starts contrasting its perceived stimuli with the stored list of stimuli kept with the flashbulb memory
 - The more similarities that are found the greater the brain thinks the probability is that it is about to experience another trauma
 - To avoid this, it increases the activation level
 - If that does not work, then it reminds the conscious mind what it is avoiding (e.g., flashbacks) or it goes into a psychological safety state, which is dissociation

Contrast

Number of people in the room	Number of chairs
Temperature of the room	What I ate last
What people said recently	What I am wearing
Time that the event happened	Noises in the room
The feel of my clothing	Smells in the room

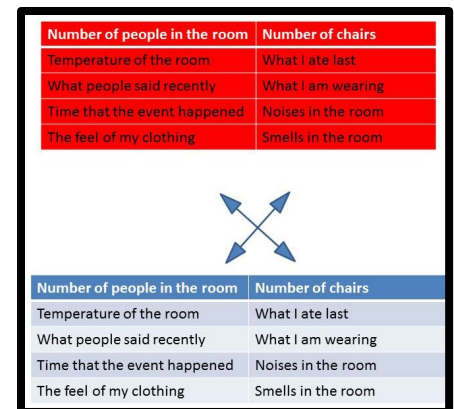


Number of people in the room	Number of chairs
Temperature of the room	What I ate last
What people said recently	What I am wearing
Time that the event happened	Noises in the room
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How the brain protects itself

- ▶ The closer a situation someone is in currently reminds them of a crisis or trauma event that they went through in the past, the more activated someone becomes.
 - With trait state memory, this means that memories of the trauma become more accessible to the brain
- ▶ As this happens, more symptoms manifest

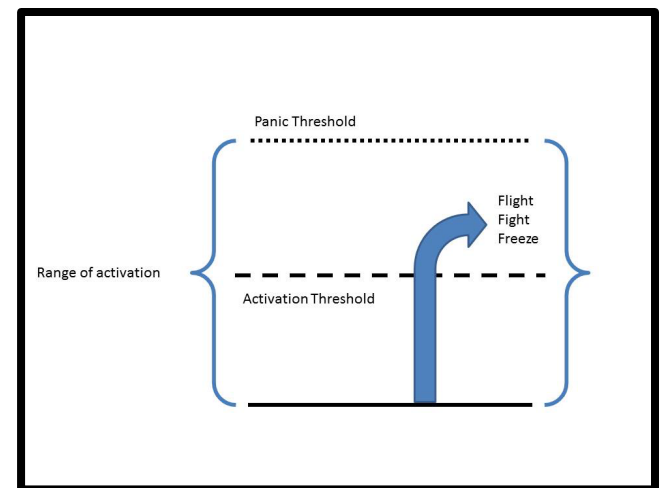
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Protection

- ▶ Increased anxiety, anger, or depression/freezing tendencies
 - Symptoms grab attention and alert the individual to the need to do something
 - (van der Kaulk, 2014; LaDoux, 2002)



Common Symptom Experiences

- ▶ Increased startle response
- ▶ Flashbacks
- ▶ Panic
- ▶ Disassociations

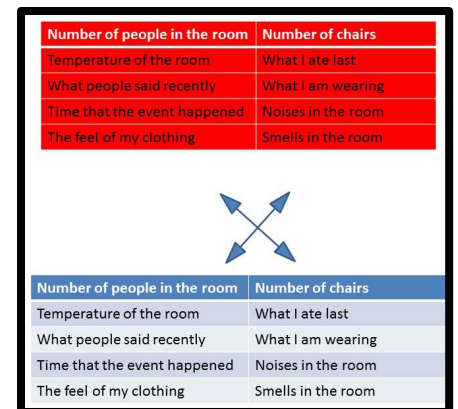
Adaptations after Trauma

- ▶ Appraisal Processes and the HPA
 - Changes from
 - Stimulus → Appraisal of threat → Reaction
 - To
 - Stimulus → Reaction → Appraisal of threat

Flashbacks

- ▶ The brain might replay memories of the trauma
 - Trait–state–memory
 - Attempt to protect

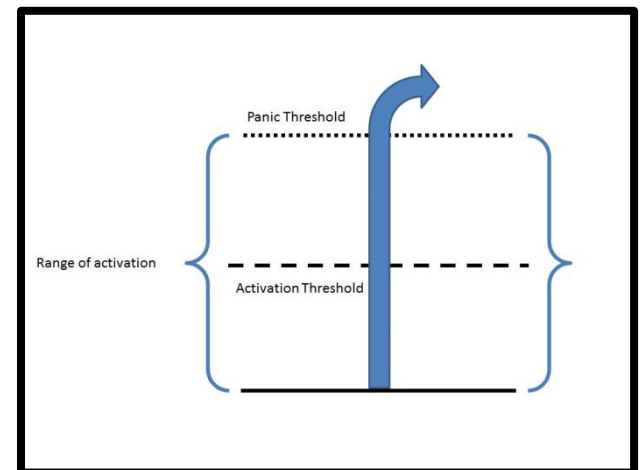
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Panic

- ▶ The brain may signal for the release of adrenaline (to protect itself)
- ▶ It may go into tonic immobility (freezing)



Disassociations

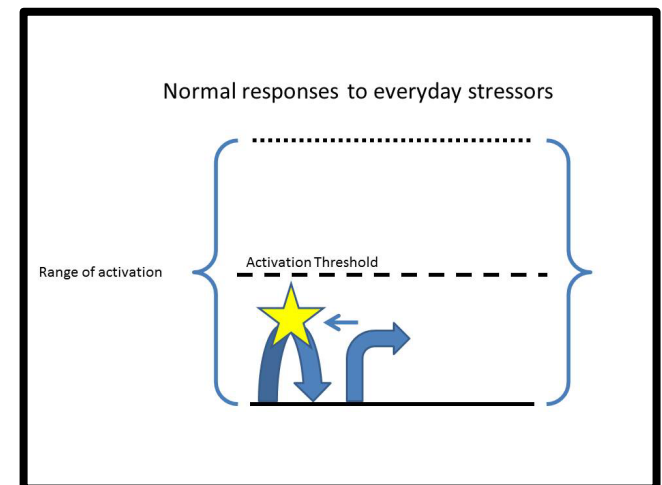
- ▶ The brain may go into a psychological state where it disassociates from the here-and-now in order to protect itself
 - It's not happening to me, it's happening to someone I am watching

Memory and Learning

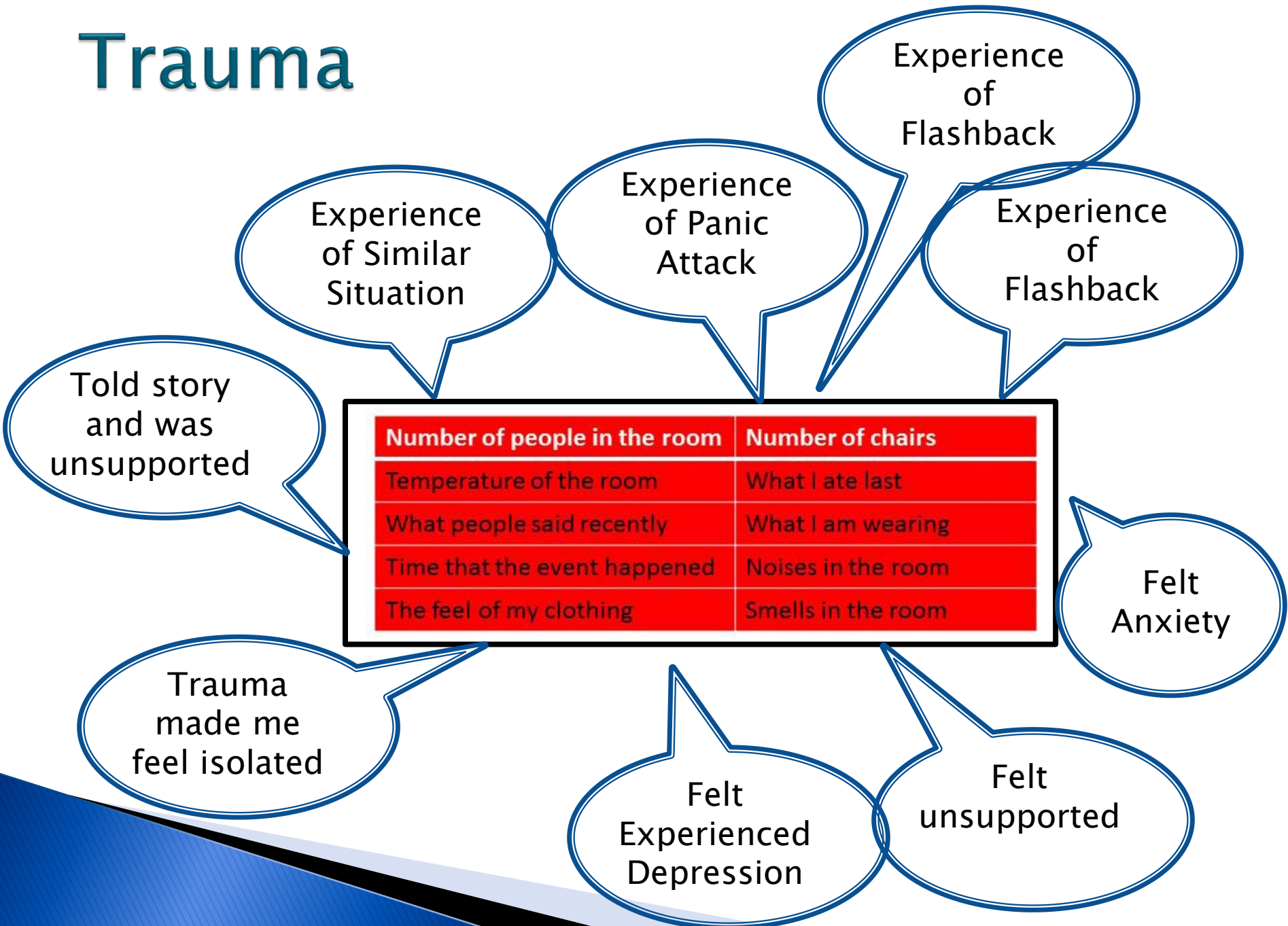


The Web of Associations

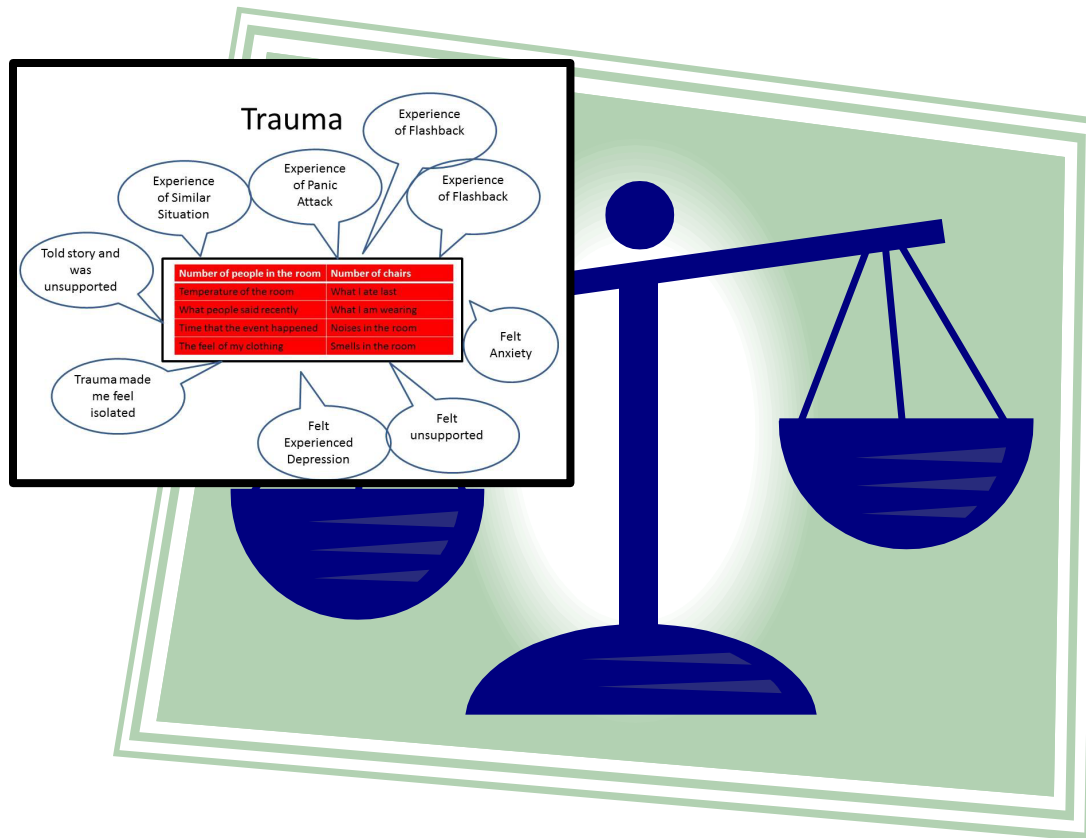
- ▶ The brain learns from trait–state memory, so...
 - When people have symptoms of trauma that experience becomes connected to the trauma
 - Trauma then goes from being an event to an event that is associated with a lot of other experiences



Trauma



Theory of trauma treatment

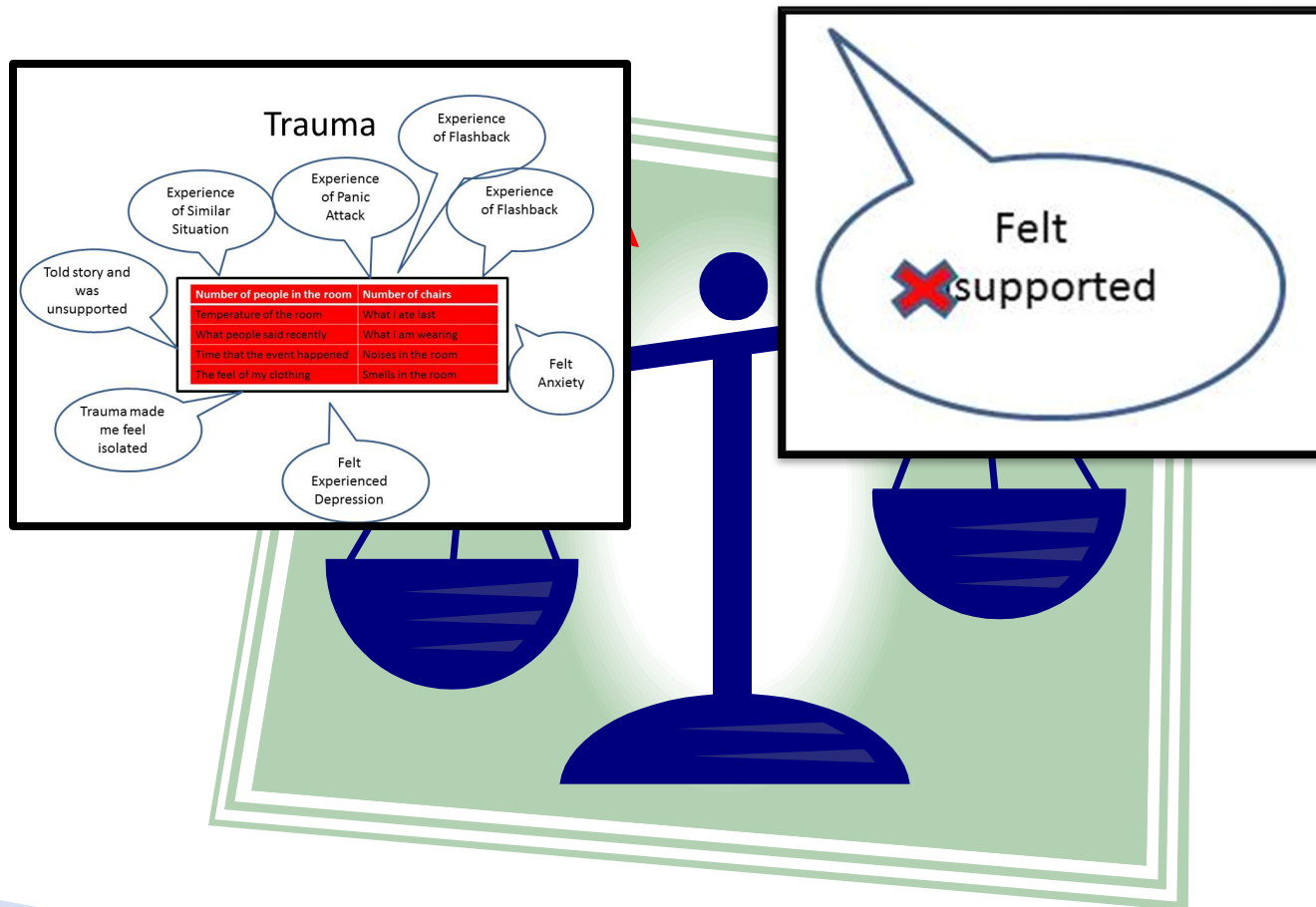


Through a positive experience

- ▶ The negative association is transformed and re-encoded



Theory of trauma treatment



Over time

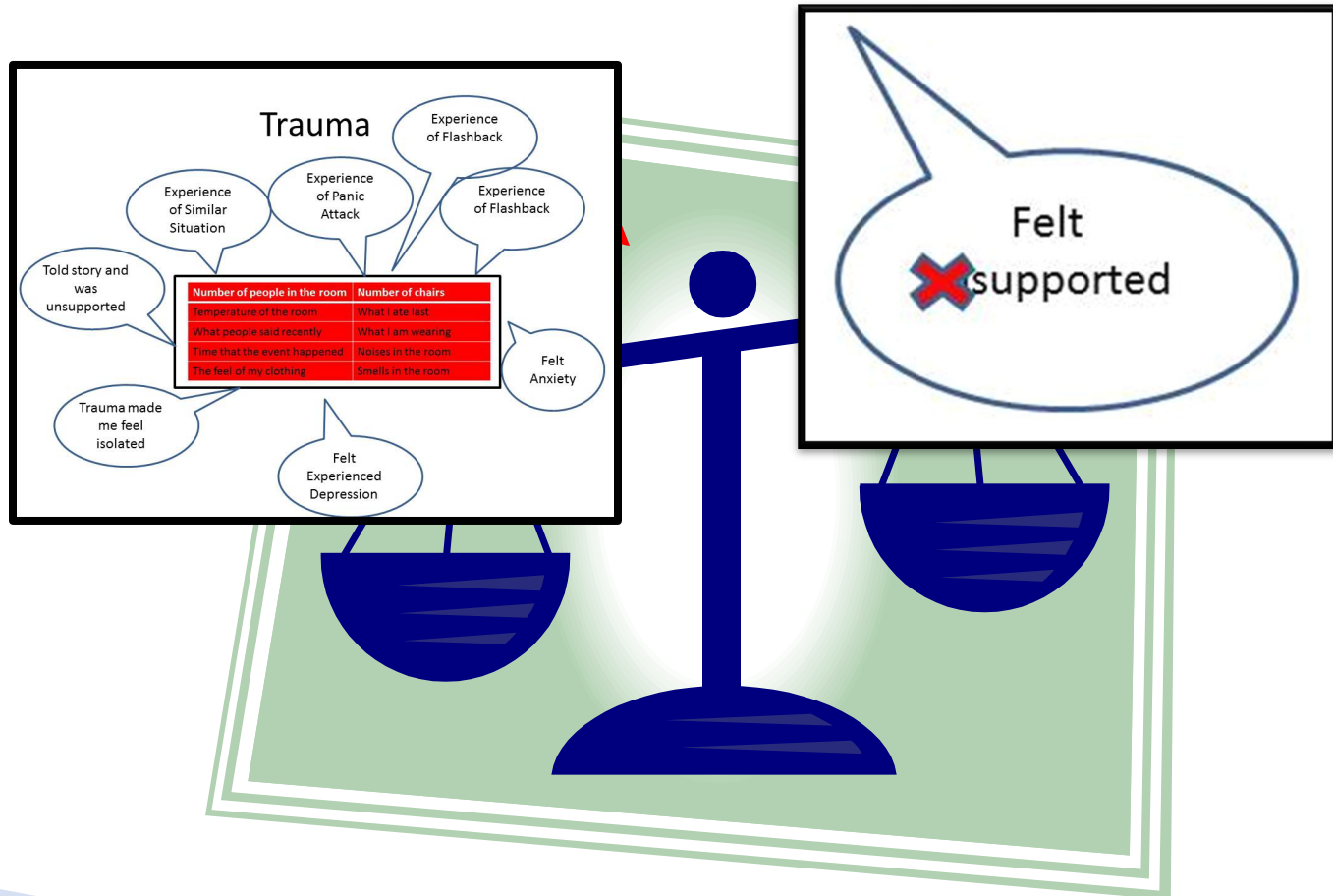
- ▶ These negative associations are addressed and can be re-encoded as positive associations
- ▶ This is slow moving work
 - Processing trauma narratives should rarely be done in a short-term setting

- (Friedman, Keane, & Resick, 2014; Dass-Brailford, 2007).

Over time

- ▶ However, if the process ends badly (early termination, bad experience with therapy) then the whole process can become encoded as a negative experience plus now there might be a negative association with doing therapy to address trauma

Theory of trauma treatment



Trauma Processing

- ▶ Due to the potential for substantial harm, as well as creating negative associations with therapy that may then later result in reluctance to engage in treatment
- ▶ Trauma should only be processed and worked on by individuals trained to do trauma processing
 - This include appropriate specialized course work, supervised clinical experience specifically in treating trauma, and being in the appropriate setting for long-term work
- ▶ (Friedman, Keane, & Resick, 2014).

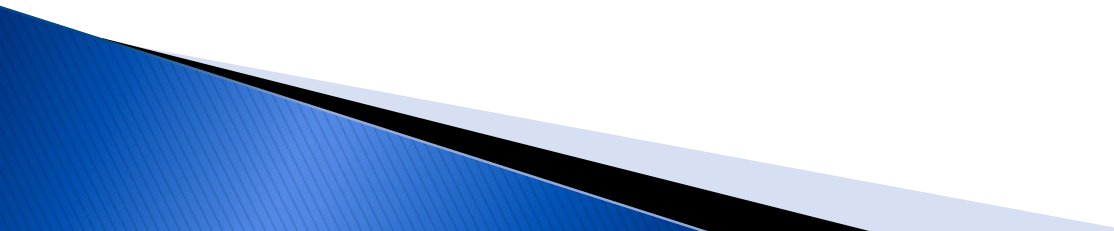
What does this mean for clinicians?

- »» Do we just ignore symptoms of trauma?

Section 2 Principles

- ▶ Incorporate Universal Routine Screenings for Trauma
- ▶ Support Control, Choice, and Autonomy
- ▶ Create a Safe Environment
- ▶ Familiarize the Client with Trauma-Informed Services

Screening Process

- ▶ Does not require patients to share the trauma narrative
 - ▶ Empower the patient to decide whether or not to discuss trauma
 - ▶ Empower the patient to decide how much to share
 - ▶ Empower the patient to build trust
- 

Skills Demonstration

- ▶ Setting the frame for assessments
 - Begin with informed consent that discusses how to empower the client's decisions to discuss trauma
 - Set a frame related to whether the client will be discussing trauma or using labeling
 - (SAMSHA, 2014a)

A few options that utilize trauma informed care principles

- ▶ Seeking Safety
 - Evidence-based practice approach
 - Group model based on teaching approaches to manage symptoms related to trauma
 - Not trauma processing
- ▶ Dialectic Behavioral Therapy
 - DBT was designed to help client with managing symptoms associated with Borderline Personality Disorder
 - Distress tolerance

(Darmouth, 2015; Najavits, 2002)

Trauma Informed Care Applications

- » Interventions based on Trauma Informed Care

Section 3 Principles

- ▶ Mediate the activation of Symptoms associated with Trauma
- ▶ Introduce Coping Skills
- ▶ Foster Trauma-Resistant Skills
- ▶ Create Collaborative Relationships and Opportunities to Participate

Psycho-education

- ▶ Empowering individuals to know why they are experiencing symptoms
 - Strengths-based approach

- ▶ Example

Skills to use to help manage symptoms related to trauma in the moment

- ▶ Grounding
 - ▶ Redirecting
 - ▶ Avoiding triggers
 - ▶ Safety planning
-
- ▶ (SAMSHA, 2014b; Curran, 2013; Najavits, 2002)

Skill Demonstrations

- ▶ Setting the frame before groups and sessions
 - If this is not a trauma processing group, then name it and explain what might happen and why
 - Informed consent
- ▶ De-escalating and grounding
 - Redirecting, grounding techniques
- ▶ Safety Planning including identifying triggers and a list of coping skills
 - Detailed safety plan created in a collaborative way

Things left to do

»» Organizational Level

Things to do that are important

- ▶ Address Secondary Trauma and Promote Self-Care for clinicians
 - This is extremely important
 - Take PTO
 - Clinicians are encouraged to consider therapy themselves
- ▶ Show organizational and administration level commitment to Trauma Informed Care

What Questions Do We Have?

»» Thank you for your attention
and time!

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