Person-Centered Trauma Symptom Management

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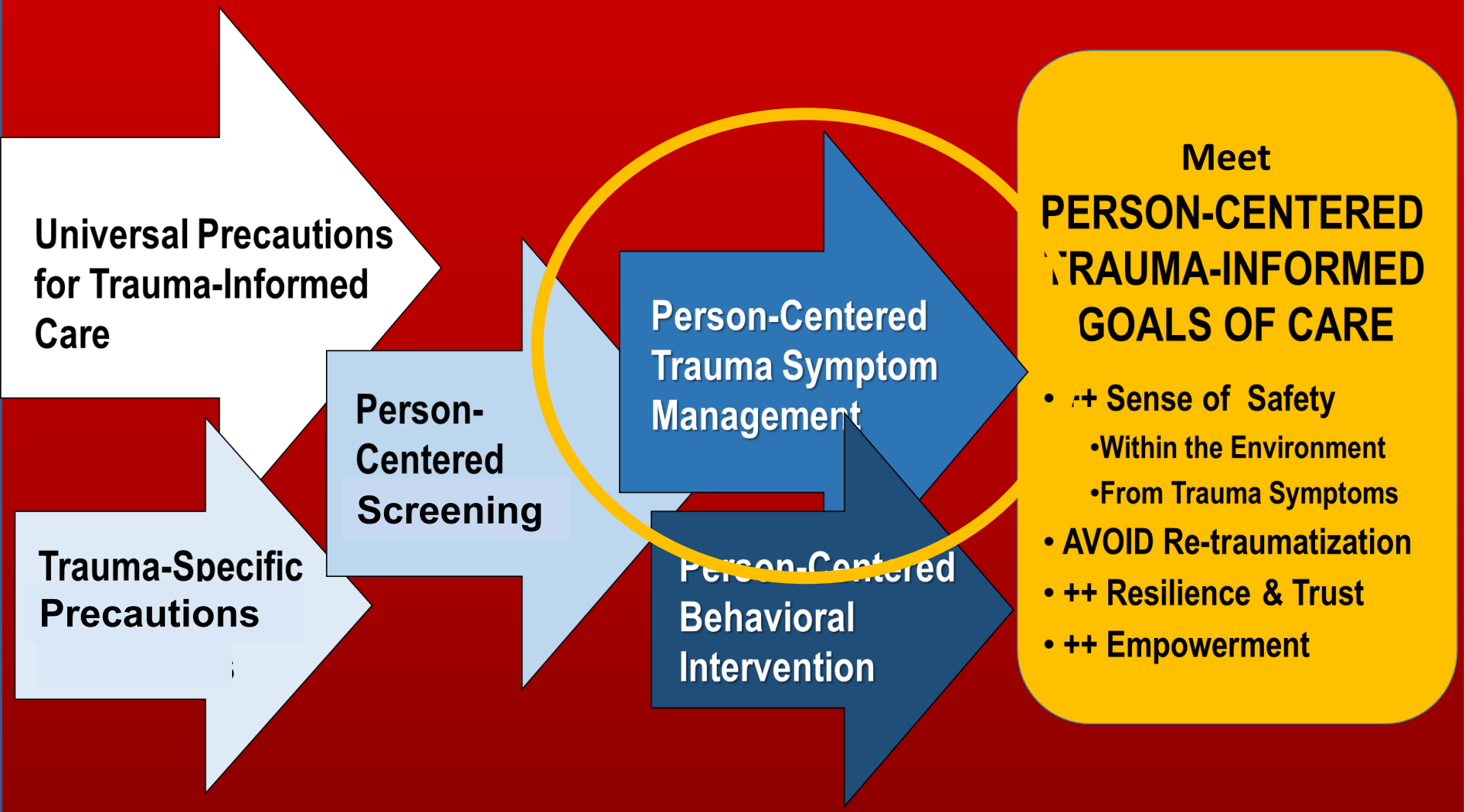
Trauma-Informed Care and the…
Trauma-Informed Organization

- **Realizes** the prevalence & impact of trauma
- **Understands** how to assess and treat the signs & symptoms of trauma
- **Integrates** this information into its policies and practices
  - **To Prevent** client re-traumatization
  - **To Promote** client/staff empowerment in a culturally sensitive framework

SAMHSA: http://www.samhsa.gov/nctic/trauma-interventions



Based on SAMHSA, *TIP-57* (2014) and Key, Kramer, Schumann, & Schiller (2019)

Take Care that Observed Symptoms are not Illness-Related

Delirium: Top Tips

1. Look carefully for delirium

PINCHME
- Pain
- Infection
- Constipation
- Hydration
- Medication
- Environment

Then use the 4AT to help diagnose delirium

www.the4at.com

SLEEP DEPRIVATION makes delirium worse: Encourage good sleep hygiene

ASK ABOUT ALCOHOL

GLASSES? Put them on!

HEARING AIDS? Put them in (& check batteries!)

2. Harness the power of the family

LISTEN to family/ friends/carers who tell you the patient is confused

ALLOW open visiting & family photos at bedside. MINIMISE ward transfers (and document all this!)

3. Find/stop culprit meds

- Amitriptyline
- Combo analgesics
- Anticholinergics
- Benzodiazepines

… can all cause or worsen delirium. Can you deprescribe anything?

4. Orientate your patient

Clocks & calendars

IF YOU REALLY HAVE NO OPTION BUT TO PRESCRIBE MEDICATION TO RELIEVE SEVERE AGITATION OR DISTRESS then use haloperidol or olanzepine at lowest possible dose, and consider benzodiazepines if antipyschotics are CI.

Dr Dan Thomas - @dan26wales
Dr Linda Dykes - @DrLindaDykes

This is a #FOAMed production: please share it far & wide!

Person-Centered Trauma Symptom Management

- Establish trust
- /PTS psychoeducation
- toms
- A
- De-escalate a
- Refer when needed

Training for the Entire Clinical Team

RAPID Intervention for TIC

We are integrating the Johns Hopkins Bloomberg School of Public Health **RAPID Model** (Everly & Lating, 2017) for post-trauma intervention by "generalists" with SAMHSA's *TIP 57* (2014).

Rapport – client-centered reflective listening
Assessment - of stress level, capacity, needs
Prioritization - of needs and resources; start point
Intervention - to stabilize/reduce trauma reactions
Disposition - where from here? care plan and referral

Rapport

Building trust between you

- **MIRROR language & body posture**
- ***LOOK* at their body language**
- ***LISTEN* very carefully to their words**
  - What is their main message, including emotional content?
- **Briefly PARAPHRASE their main message**
  - **WAIT** until they have expressed an entire emotion or thought and have paused. Start with the emotion that seems most important.
  - Use **reflective paraphrasing** and **open-ended questions** that acknowledge and validate their distress.
  - **Acknowledge grief and loss.**

Provide a sense of <u>interpersonal support</u>
that fosters resilience, trust, and mutual understanding.

Everly & Lating (2017)

Rapport

Building trust between you

- **Reflective paraphrasing:** **show your understanding**

  "It sounds like this illness has been devastating on so many levels"

- **Open-ended questions:** **Invite and allow sharing of information**

  "I'm so sorry, that doesn't seem fair, does it?"

- **Speak calmly and with kindness**
- **Be present and mindful**
- **Be honest**

The goal is connection

Everly & Lating (2017)

Assessment

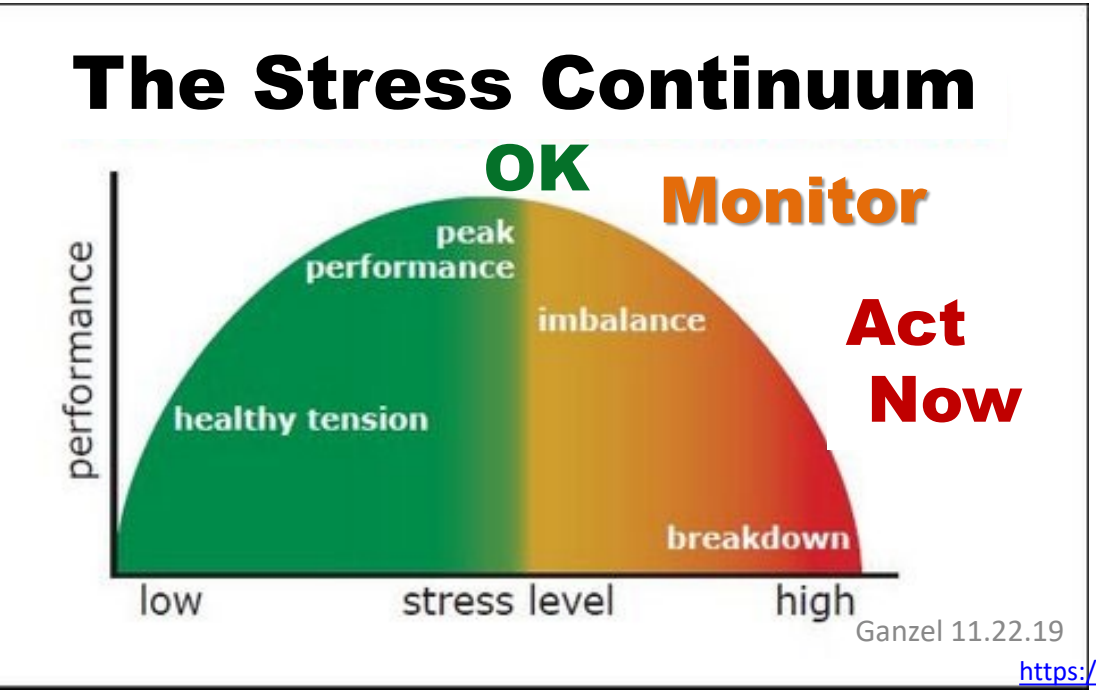
Where is this person on the stress continuum?

What do they need *now*?

Eustress – motivating, engaging

Distress – mild, coping engaged

Dysfunction – Incapacitating, coping overwhelmed



- Know your PTS signs & symptoms.
- Look and listen for evidence of specific triggers
- Be aware of capacity

Adapted from Everly & Lating (2017)

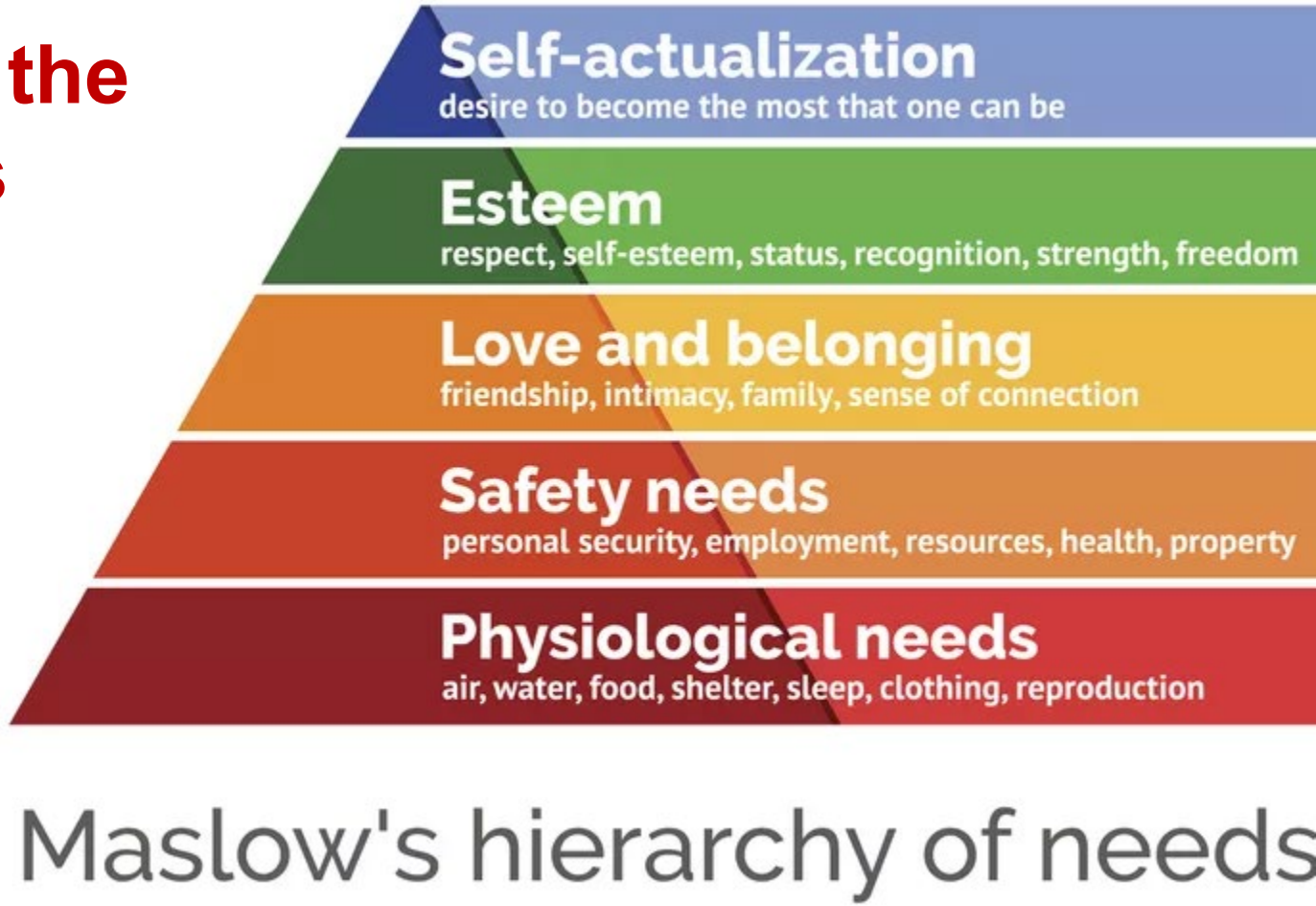
https://www.ithaca.edu/sacl/healthpromotion/gallery/6753/?image_id=56026

Prioritization = triage

Recognize who needs additional help and resources

when help and resources are limited

Remember the individual's priorities



Maslow's hierarchy of needs

Adapted from Everly & Lating (2017)

https://www.thoughtco.com/maslows-hierarchy-of-needs-45825

Intervention

Reduce Moderate Distress

- **Guided imagery** – calm, peaceful place; light stream
- **Trauma/PTS psychoeducation** (answers "*why am I reacting this way?").* **DO** normalize stress reactions ("*you are having a normal response to an abnormal situation*"). **Don't** pathologize ("*this is a symptom of PTSD*").
- **Foster a sense of control and an ability to cope** ("*what have you done to manage stressful situations in the past?*")
- **Enlist interpersonal support** from caregivers, friends, peers.

Reduce Acute Distress – Grounding Techniques

- **Breathing Techniques** – Inhale via nose, exhale via mouth; Square breathing
- **Orienting** - Name all the red (or blue or yellow) objects in room
- **Somatosensory Techniques** – Toe wiggling; Feel the ground; Drink ice water; Feel ice in your hand; Review all 5 senses (what do you see? Smell? Taste? Feel? Hear?); Smell a favorite scent; Listen to favorite music

Adapted from SAMHSA *TIP-57* (2014); Everly & Lating (2017)

Grounding: Orient to Here-and-Now

"You seem to feel very scared/angry right now.

You're probably feeling things related to what happened in the past. Now, you're in a safe situation. Let's try to stay in the present.

Take a slow deep breath, relax your shoulders, put your feet on the floor; let's talk about what day and time it is, notice what's on the wall, etc. What else can you do to feel okay in your body right now?"

SAMHSA (2014, p. 98)

Disposition

Care plan and referral

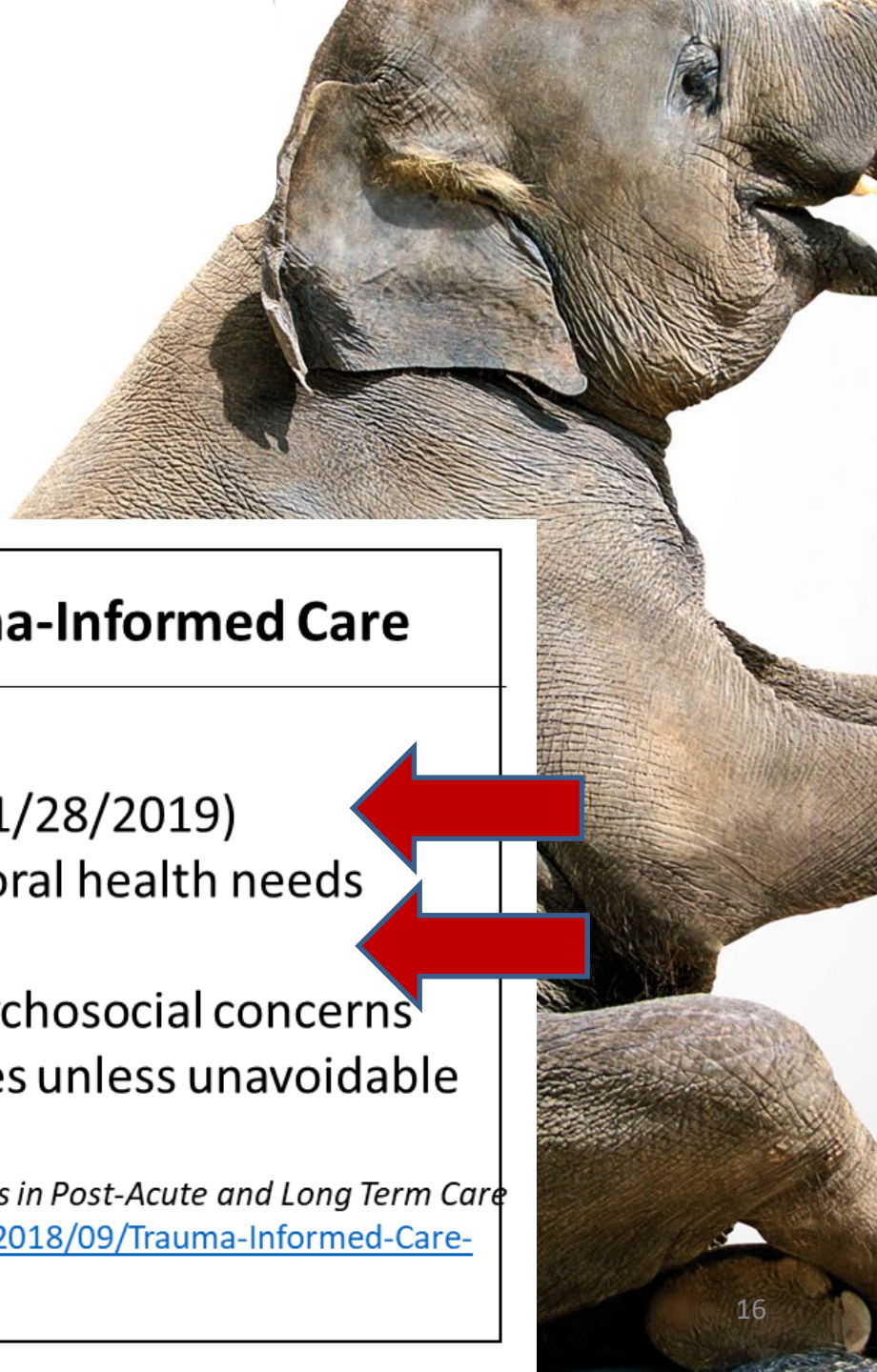
Care Plan

- **Include** all trauma-related information in patient's chart
- **Discuss/share** trauma-related observations, cues, history, potential triggers in interdisciplinary team meeting
- **Modify** the care plan to avoid triggers and re-traumatization & minimize symptoms

Referral

- Refer right away if individual requests it
- Refer right away if symptoms are severe, coping is overwhelmed
- Refer after efforts to stabilize symptoms are needed three times

Based on SAMHSA, *TIP-57* (2014) and Key, Kramer, Schumann, & Schiller (2019)



F-Tags that Support Trauma-Informed Care

F659 Qualified persons
F699 Trauma informed care (effective 11/28/2019)
F741 Sufficient competent staff, behavioral health needs
F740 Behavioral health services
F742 Treatment/services for mental-psychosocial concerns
F743 No pattern of behavioral difficulties unless unavoidable

CMS. *Resources to Support Trauma Informed Care for Persons in Post-Acute and Long Term Care Settings* (pg.3) https://www.lsqin.org/wp-content/uploads/2018/09/Trauma-Informed-Care-Resources.pdf

The CMS Final Rule & Friends

Since the implementation of Phase 1 requirements for behavioral health care to LTC residents, a dynamic new consulting industry has arisen to provide behavioral health services to long-term care facilities.

In Phase 3, this industry will be adapting to providing trauma-specific services and behavioral intervention for LTC residents who are trauma survivors.

Treatment may have somewhat different goals of care in these settings, but physical and cognitive capacity will determine strategy – not exclusion from this higher level of care

Shirley

Shirley had stopped sleeping at night following becoming incontinent. Triggered the trauma of her parents shooting her puppy, who had peed indoors.

- Shirley did not connect her own incontinence with her puppy's.
- She did not fear that the staff would shoot her.

- BUT she was still distressed and she was staying up all night to be sure that she would use the bathroom properly
- It wasn't working very well, which made her more anxious

JUST KNOWING ABOUT THE PUPPY helped the staff feel less frustrated and think more productively about ways to help. They reached out to the consulting behavioral health specialist.

Shirley

Shirley had stopped sleeping at night following becoming incontinent. Triggered the trauma of her parents shooting her puppy, who had peed indoors.

The facility's consulting behavioral health specialist supported the staff in helping Shirley understand her trauma response. Shirley was cognitively capable and responded well to trauma psychoeducation. Staff members that she trusted helped to normalize her stress reactions and fostered a sense of control and her ability to cope with -- and accept -- her own incontinence. They also sat with her while she grieved the loss of her puppy for the first time. Shirley slowly returned to sleeping at night.

Making peace with the past

Trauma-Specific Interventions

Three Gold-Standard Trauma-Specific Treatments to reduce symptoms of posttraumatic stress

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Exposure Therapy
- Eye Movement Desensitization and Reprocessing (EMDR)

Any of these are appropriate if the resident has plenty of time and is healthy, alert, and competent (e.g., the average behavioral health patient).

If not, then use EMDR.

EMDR *to reduce symptoms*

- **Brief, effective, evidence-based**
  - Includes 1-session protocols
- **Clients don't have to "get worse first"**
- **Low cognitive demand**
  - No homework
- **No detailed description of trauma**
- **Multiple formats for bilateral stim**
  - Tapping, Sound (usually not eyes w/ older adults)
- ***Modified protocols for dementia***

Capacity determines clinical strategy

not exclusion from higher levels of care.

Jack

Nightmares about a combat trauma. Saw the Japanese pilot's face at the moment before he shot him down. Increasingly depressed and tearful during the day.

EMDR "On-the-Spot" Intervention

The therapist invited Jack to reflect on this memory while she did EMDR bilateral stimulation. After 10 minutes or so of "on the spot" EMDR, he started to calm down and finally said he was't upset any more because "*I think that that pilot and I were a lot alike, both good soldiers...but we really only wanted to get home to see our families.*" In the days after that 10 minute encounter: nightmares ceased, his mood improved, and his feisty, slightly "off-color" sense of humor (both resilience resources) returned.

Jack

A little more

Jack began to talk about a "last wish" to once again fly in a glider. The hospice found a pilot with a charitable heart at a regional sail plane club. He flew a motorized glider to a local county airstrip. With a large crowd of family and friends watching, he was lifted out of his wheelchair, strapped into the plane, given one last O_2 treatment, and off they went into a clear, blue sky.

Jack died less than two weeks later.

Trauma treatment is possible with seriously ill and dying patients

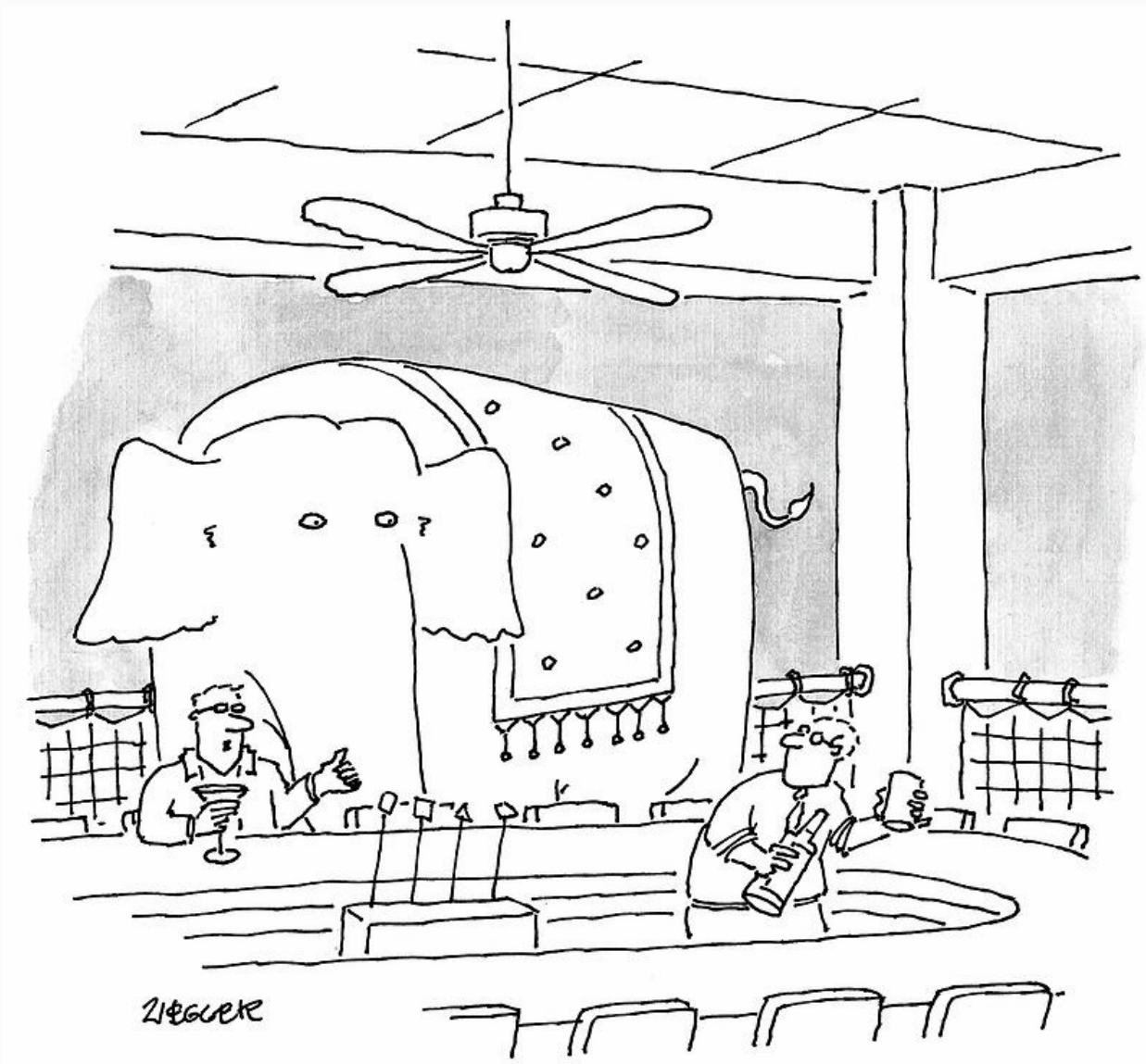
ICGI/FLGEC

CLINICAL FELLOWS PROGRAM in TRAUMA-INFORMED PALLIATIVE CARE

- **EXPAND delivery of trauma-informed mental health care to seriously ill geriatric clients in rural NY**
- **DEVELOP strategies for bringing evidence-based trauma treatment to the bedside**
- **FOCUS on trauma symptom reduction (palliation)**

Unresolved Trauma

Peace with the Past



"Oh, and maybe some peanuts?"

THANKS

for thinking about this important topic with me

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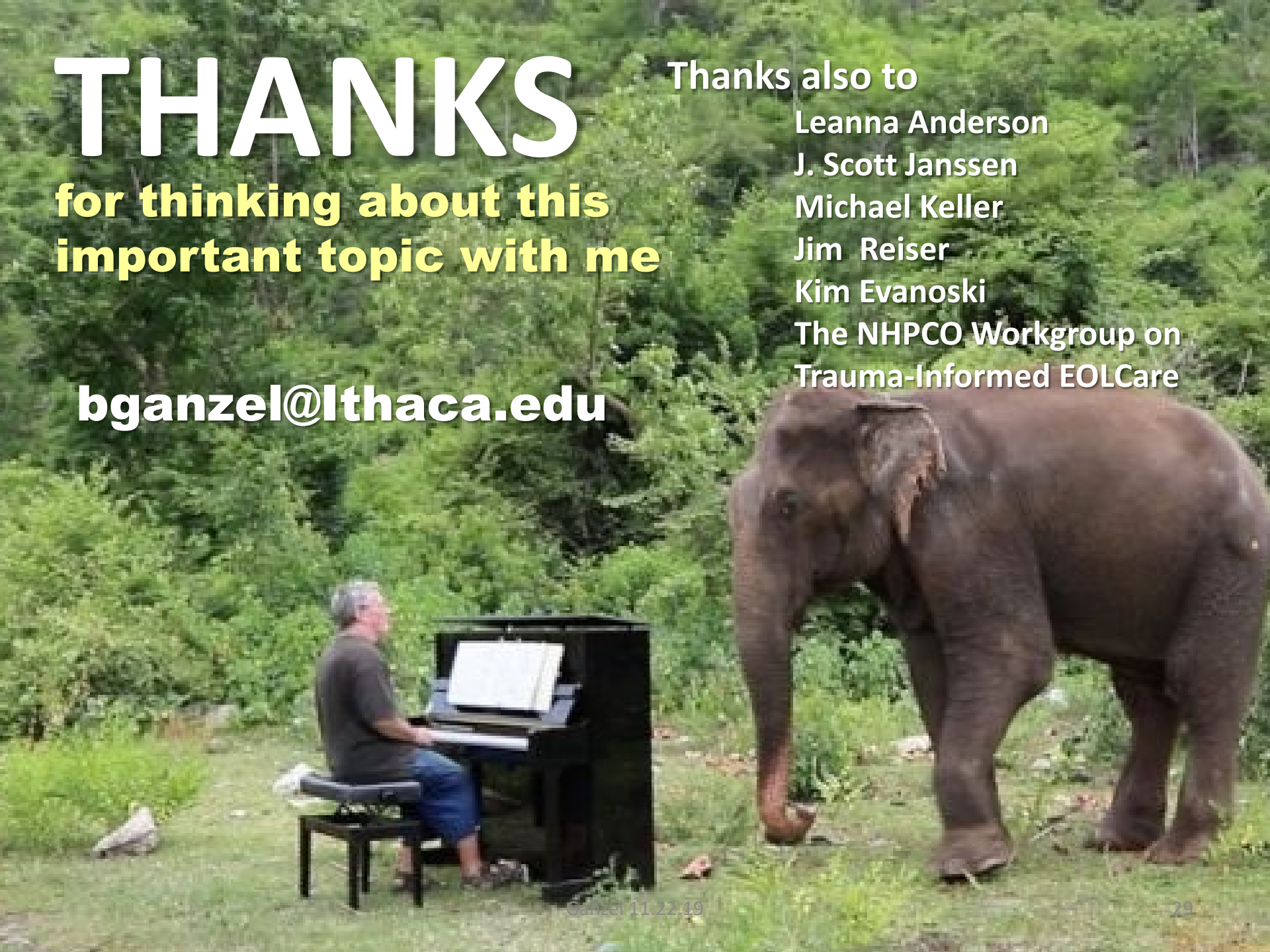

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