TRAUMA-INFORMED CARE TEACHING AID

The Trauma-Informed Care Teaching Aid Toolkit (TICTAT)

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HRB Health Research Board

Acknowledgement

Thank you to the students of the Schools of Clinical Speech & Language Studies, Dentistry, and Pharmacy, for piloting and providing feedback on the journey maps and overall content of the TICTAT.

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Sponsored By: The Health Research Board, the Royal College of Physicians of Ireland & the Health Service Executive

Version Number: 0.0.1

Published Date: 6 November, 2023

Subject: Trauma-Informed Care Education

ISBN: TBD

Cite this document as:

Swords, M., Jagoe, C., Mac Giolla Phádraig, C., Ní Sheachnasaigh, E., Vallières, F. (2024). The Trauma-Informed Care Teaching Aid Toolkit (TICTAT).

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PSYCHOLOGICAL TRAUMA

WHAT IS PSYCHOLOGICAL TRAUMA?

Psychological trauma is an emotional response that we may have when exposed to stressful or traumatic events (American Psychological Association, 2022). Trauma can develop after acute or chronic exposure to traumatic events. Acute events include car accidents, assault, or exposure to other life-threatening events or events that are perceived as life-threatening. Chronic exposure tends to take the form of long-term abuse, such as intimate partner violence, child abuse, or vicarious exposure to long-term abuse of others within a household or shared living space.

Trauma is a widespread experience. According to the World Mental Health surveys, around 70% of the population has been exposed to at least one traumatic event, with 30.5% exposed to four or more events (Benjet et al., 2016). Regarding adverse childhood experiences (ACEs), where children were exposed to traumatic events, over 50% of respondents had experienced at least one ACE, while 25% had experienced two or more (Felitti et al., 1998). In the Republic of Ireland, rates of lifetime exposure to one traumatic event stand at around 82.3%, while 67.8% reported exposure to two or more traumatic events (Hyland et al., 2021). As a result, the ability to work with psychological trauma is of increasing importance for students of health disciplines and professionals.

WHAT CAN PSYCHOLOGICAL TRAUMA LOOK LIKE?

Trauma responses come in many forms. Current research shows that there are four main responses to someone's trauma being triggered: fight, flight, freeze and fawn. These responses can be organised into hyperarousal and hypoarousal.

When someone becomes hyperaroused, they tend to go into fight or flight. They may become visibly agitated, hypervigilant, fearful, angry and/or impulsive. Their thoughts may race, they may experience intrusive thoughts and feelings, and they may have flashbacks or nightmares.

When someone becomes hypoaroused, they tend to go into freeze or fawn. Their affect may become flat or numb, they may seem empty and become cognitively dissociated. They may seem helpless or hopeless.

TRAUMA-INFORMED CARE

Trauma-informed care (TIC) takes the knowledge that trauma is common and could affect anyone who accesses health care services, and applies that to general principles that can be applied to any care discipline. TIC has been used in homeless services, education, prisons and social work to great effect: trauma-informed services see lower patient and client distress, better work-life balance, and lower rate of assaults (Blair et al., 2017; Brown et al., 2022; Dorado et al., 2016; Elwyn et al., 2015). There are many different structures of TIC, but the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) has a list of six principles that are often used to scaffold both the understanding and application of TIC: safety; trustworthiness & transparency; peer support; collaboration & mutuality; voice, choice & empowerment; and sensitivity towards cultural, gender and historical issues. These principles all aim to reduce the retraumatisation of patients while they are accessing the service by keeping them within their windows of tolerance as much as possible.

SAFETY

The principle of safety in TIC refers not just to the physical safety of patients and professionals, but also to their psychological safety. In promoting safety, both patients and professionals should feel physically and psychologically safe, and that their physical environment and interpersonal reactions promote that sense of safety (SAMHSA, 2014).

This may take the form of providing comfortable seating arrangements, replacing harsh lights with softer lights, greeting patients warmly, and promoting self-care for patients and professionals; eventually leading to following the other five principles and promoting safety through them.

TRUSTWORTHINESS & TRANSPARENCY

Trustworthiness & transparency generally refers to an organisational level of transparency surrounding their decision-making processes. This transparency aims to promote trust with patients and their families or loved ones among the professional staff there (SAMHSA, 2014). In line with privacy policies, the more transparent the process the more trustworthy you may seem as a professional.

This may take the form of being direct and open in communicating wait times to patients, recognising that as an authority figure you may be viewed with distrust regardless of your demeanour, managing both patient and professional expectations with full transparency of the limits of your ability, and establishing clear boundaries of the organisation's role and capability.

PEER SUPPORT

Peer support and mutual self-help provide a backbone upon which an organisation can build trust, collaboration, safety, and the ability to collaborate with their patients. Peers in this instance refers to those with their own lived experience of trauma, who are not staff members of the organisation. This may not be possible to immediately implement for all patients in all organisations, but can be planned for as part of a long-term strategy.

This may take the form of introducing patients to other patients or peer support groups that are known to the service, assessing a patient's strengths and utilising those strengths, managing conflict to potential employment of patients or locals in the organisation to provide peer support to patients.

COLLABORATION & MUTUALITY

In TIC, collaboration and acknowledgement of the power dynamics present in care can serve as a way to involve patients in their own care and build trust in a safe way with them. Collaboration with patients in their own care can lead to their empowerment and feeling a sense of control in their own care, which will lead to healing. In levelling the power dynamic between professional and patient, that sense of empowerment and equality can add to an organisations transparency and provide a safe environment where

both professionals and patients trust each other to participate fully in care (SAMHSA, 2014).

This may take the form of creating a partnership between patients and staff, ensuring staff communicate their role as supporters in patients' care, and involving the patient in as many decisions relating to their own care as possible while also treating them like an equal.

VOICE, CHOICE & EMPOWERMENT

Empowering patients to voice their concerns and offering them choices in their care is a vital part of TIC. Trauma can often result from a loss of control, and counteracting that by offering control over care within reason can serve as a major source of healing for patients. Understanding where and how patients have historically been disempowered and have been denied a voice and/or choice should lead to co-developing a plan of action of care which serves both patients and professionals.

This can take the form of offering choices to patients, understanding and managing expectations of care, seeking and acting on patient feedback and trying to accommodate as many patient requests as the service will allow.

INTERSECTIONALITY OF IDENTITY

In order to work with issues surrounding cultural stereotypes and biases (e.g. stereotypes based on race, ethnicity, gender identity, sexual orientation, religion, age, etc.), an organisation must come to terms with the trauma that can be associated with said stereotypes and biases. Actively moving past these stereotypes can take the form of offering culturally responsive and sensitive care, providing gender-responsive services and recognising and addressing historical trauma.

This can take the form of accepting that biases are a normal human response, understanding staff's specific biases, acknowledging culture and providing culturally specific supports. It can also take the form of acknowledging the additional impacts that having an intersection of identity has on trauma and a person's reaction to that trauma.

PERSONAS

As part of the TICTAT, we recommend the use of patient and professional personas to provide a more human and relatable element to trauma-informed education. Patient personas give background information on the person who accesses the service, such as their own professional background, their lives outside of accessing service, and most importantly their traumatic histories. Their traumatic histories include their specific experience of trauma, whether it results from an acute or chronic source, what may trigger their trauma reactions and what their trauma reaction looks like.

The use of these personas allows students to empathise with these fictional patients and professionals and imagine what effect their actions may have on the patient and professional in terms of a trauma trigger. There are a number of sample personas offered in this toolkit, as well as a guide on how to design your own persona to better fit your teaching.

PATIENT PERSONAS

In order to work with issues surrounding cultural stereotypes and biases (e.g., stereotypes based on race, ethnicity, gender identity, sexual orientation, religion, age, etc.), an organisation must come to terms with the trauma that can be associated with said stereotypes and biases. Actively moving past these stereotypes can take the form of offering culturally responsive and sensitive care, providing gender-responsive services and recognising and addressing historical trauma.

Ali

Ali is a 37-year-old primary school teacher. He enjoys watching movies with his husband, and spending time with their cats. When Ali was young, he was often subjected to physical and verbal abuse by his parents, and often has a hard time trusting people in authority. When triggered, he tends to become hypo-aroused, becoming very quiet and seeming absent.

Ann

Ann is a 74-year-old retired geneticist. She sustained a left-hemisphere stroke 8 weeks ago. She has difficulties with comprehension and has only a single-word output, but she is a proficient gesture user. She has a long experience of domestic violence and is currently experiencing it. When triggered, she tends to become hypo-aroused, becoming numb and seeming spaced out.

Aoife

Aoife is a 34-year-old insurance sales agent who works from home. She enjoys cooking but finds that she often does not have the energy to cook after work due to her chronic fatigue. She often uses an electric wheelchair as a result of her chronic fatigue, as it enables her to move without tiring herself out, but some days she manages without a mobility aid or with a cane. Aoife was a victim of intimate partner violence for a few years and was recently able to leave her abusive partner. She tends to become hyper-aroused when triggered, becoming agitated and flustered.

STAFF/PROFESSIONAL PERSONAS

Alice, Speech and Language Therapist

Alice is a 39-year-old speech and language therapist. She lives alone with her dogs, and enjoys carving flowers and other plants with wood. She often takes long walks in the park and will sketch certain plants for her own relaxation. Her brother passed away in the AMAU two months ago, and while she has seen patients from his passing she is reminded of his death whenever she walks into the AMAU. She finds it difficult to go to work.

Niamh, Community Pharmacist

Niamh is a 27-year-old community pharmacist. She has recently qualified and moved to work as a locum in a disadvantaged area. The pharmacy where she works was recently burgled at knifepoint, and since then she has been on edge coming into work. Additionally, a few days ago she consulted a male patient who acted in an inappropriate way in the consulting room.

Seán, Dentist

Seán is a 43-year-old dentist. He is married, with two teenagers who both play Gaelic football and hurling. Seán himself used to hurl, but gave it up after it became too difficult to balance with college work. While

he generally faces no issues with his patients, a few years ago he was verbally threatened with violence by a patient who shouted at him. While normally this would not have triggered anything in him, in the last few years he has frozen up when he has heard shouting.

JOURNEY MAPS

Journey maps show the patient's journey through a routine assessment or interaction with the health services. They begin with entering service, moving through interactions with reception or salespeople all the way through to the patient or staff leaving the service for the day. They provide a space for students to imagine the cognitive, emotional, and physiological status of the patient as they interact with staff and the environment around them.

Sample journey maps for the three patient personas are provided below. Guidance on how to design a journey map to better fit your own personas or teaching methods is also provided.

HOW TO USE THE TEACHING AID

PERSONAS

Personas form the human component of the TICTAT. Students will have access to the personas' general information, but just as in real practice they will not have access to the personas' trauma history or trauma reactions. The focus of the TICTAT's learning is not to provide clinical care to patients. It is to show that anyone, both patients and professionals, can be affected by psychological trauma.

Introduce your students to the persona – give their name, their age, their profession, and as much or as little personal information about them as you wish. Keep their history of psychological trauma from students until they have worked through a journey map and discussed how a patient and professional might react cognitively, emotionally and physiologically to the routine assessment.

JOURNEY MAPS

The journey maps are specific to each practice and provide a sketch of a persona's interaction with the practice. These are the foundations upon which the trauma-informed practice is built, as they allow students to reflect on how patients and professionals feel at every step of assessment.

When you have introduced the patient and professional personas, guide your students through the patient's journey. There are a number of ways to do this depending on the size of the student group: for small tutorials or seminars of 5 or so, we recommend working through the journey map with students; for larger groups, split the students into groups and prompt them to answer the prompts themselves at each stage. Have physical worksheet copies of the journey map on hand for shorthand answers if in person, if online use a whiteboard that a group leader can control.

When students have worked through their initial assessment journey, reveal the trauma history of both the patient and the professional involved. Ask students if they think anything in the cognitive, emotional and physiological reactions would change upon learning of the personas' trauma histories. In a small tutorial or seminar, you could lead a wider discussion about trauma reactions and how they might guarantee certain behaviours or feelings.

Here are a sample selection of topics to discuss upon revealing the personas' trauma histories. You can design your own practice-specific topics that centre around a theme of being trauma-informed:

1. What hyper-arousal and hypo-arousal mean, and a discussion of fight, flight, freeze, and fawn.

   a. How can you recognise these reactions?

2. How the knowledge of the patient's trauma history changes students' answers to the journey map prompts, if at all.

   a. Prompt students to think cognitively, emotionally, and physiologically – what is the patient thinking? What are they feeling? How is their body reacting?

3. How the knowledge of the professional's trauma history changes students' answers to the journey map prompts, if at all.

   a. Prompt students to think cognitively, emotionally, and physiologically – what is the professional thinking? What are they feeling? How is their body reacting?

4. Are there any actions that the professional could or should take to prevent a patient's trauma reaction?

   a. Are there any actions that could maintain a patient's trauma reaction at a certain level?

   b. Are there any actions that would worsen a patient's trauma reaction?

5. If you have introduced the principles of trauma-informed care to your students, discuss how the organisation may prevent, maintain, or worsen trauma reactions for both patients and professionals. These are deep topics and may require additional reading, particularly with regards to intersectionality of identity.

   a. Safety: Is the environment safe? What physical/psychological safety measures are in place? Can this sense of safety be improved?

   b. Trustworthiness & Transparency: Is the service transparent? Was trust built by the professional? Can this be improved?

   c. Peer Support: What peer support is available in the service, for both patients and professionals?

   d. Collaboration & Mutuality: Does the service allow collaboration between patients and professionals?

   e. Voice, Choice & Empowerment: Do patients have a voice in their own care? Can the service offer them a choice?

   f. Intersectionality of Identity: What additional issues might patients or professionals face if they are women/transgender/non-binary/gender non-conforming? Are there issues regarding ethnicity and/or race for patients or professionals who are Travellers/Black/Asian? Does class impact patient and professional responses to treatment and trauma? Does patients' or professionals' sexuality?

REFERENCES

Bargeman, M., Abelson, J., Mulvale, G., Niec, A., Theuer, A., & Moll, S. (2022). Understanding the Conceptualization and Operationalization of Trauma-Informed Care Within and Across Systems: A Critical Interpretive Synthesis. The Milbank Quarterly, 100(3), 785-853. https://doi.org/https://doi.org/10.1111/1468-0009.12579

Benjet, C., Bromet, E., Karam, E. G., Kessler, R. C., McLaughlin, K. A., Ruscio, A. M., Shahly, V., Stein, D. J., Petukhova, M., Hill, E., Alonso, J., Atwoli, L., Bunting, B., Bruffaerts, R., Caldas-de-Almeida, J. M., de Girolamo, G., Florescu, S., Gureje, O., Huang, Y., Lepine, J. P., … Koenen, K. C. (2016). The epidemiology of traumatic event exposure worldwide: results from the World Mental Health Survey Consortium. *Psychological medicine, 46*(2), 327–343. https://doi.org/10.1017/S0033291715001981

Blair, E. W., Woolley, S., Szarek, B. L., Mucha, T. F., Dutka, O., Schwartz, H. I., ... & Goethe, J. W. (2017). Reduction of seclusion and restraint in an inpatient psychiatric setting: a pilot study. *Psychiatric Quarterly, 88,* 1-7.

Brown, T., Ashworth, H., Bass, M., Rittenberg, E., Levy-Carrick, N., Grossman, S., Lewis-O'Connor, A., & Stoklosa, H. (2022). Trauma-informed Care Interventions in Emergency Medicine: A Systematic Review. *The western journal of emergency medicine, 23*(3), 334–344. https://doi.org/10.5811/westjem.2022.1.53674

Dorado, J. S., Martinez, M., McArthur, L. E., & Leibovitz, T. (2016). Healthy Environments and Response to Trauma in Schools (HEARTS): A whole-school, multi-level, prevention and intervention program for creating trauma-informed, safe and supportive schools.*School Mental Health, 8,* 163-176.

Elwyn, L. J., Esaki, N., & Smith, C. A. (2015). Safety at a girls secure juvenile justice facility. Therapeutic Communities: *The International Journal of Therapeutic Communities, 36*(4), 209-218.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine, 14*(4), 245-258. https://doi.org/10.1016/S0749-3797(98)00017-8

Hyland, P., Vallières, F., Cloitre, M. et al. Trauma, PTSD, and complex PTSD in the Republic of Ireland: prevalence, service use, comorbidity, and risk factors. *Soc Psychiatry Psychiatr Epidemiol* **56,** 649–658 (2021). https://doi.org/10.1007/s00127-020-01912-x

Substance Abuse and Mental Health Administration (SAMHSA). (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf