Translating Trauma-Informed Principles into Trauma-Responsive Practices for Pregnant and Parenting Patients with Substance Use Disorders and Their Families

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Obstetrics and Gynecology

Disclosures

none

Objectives

1. Identify at least three ways that trauma-informed principles can be applied in trauma-responsive practices
2. Identify trauma triggers and practice calming and grounding strategies that can be employed within treatment settings
3. Explore the presence of and effects of vicarious trauma and develop a menu of strategies regarding self-care

Trauma

The event + the way the event is experienced + the effect on the person= Trauma

Adapted from Griffin,E., (2012). Presentation at the NIDA/ACYF experts meeting on trauma and child maltreatment; Wilson, C. and Ford, J., (2012). SAMHSA's Trauma and Trauma-Informed Care Experts Meeting; Andersen, R., (2012). SAMHSA's Trauma and Trauma-Informed Care Experts Meeting.

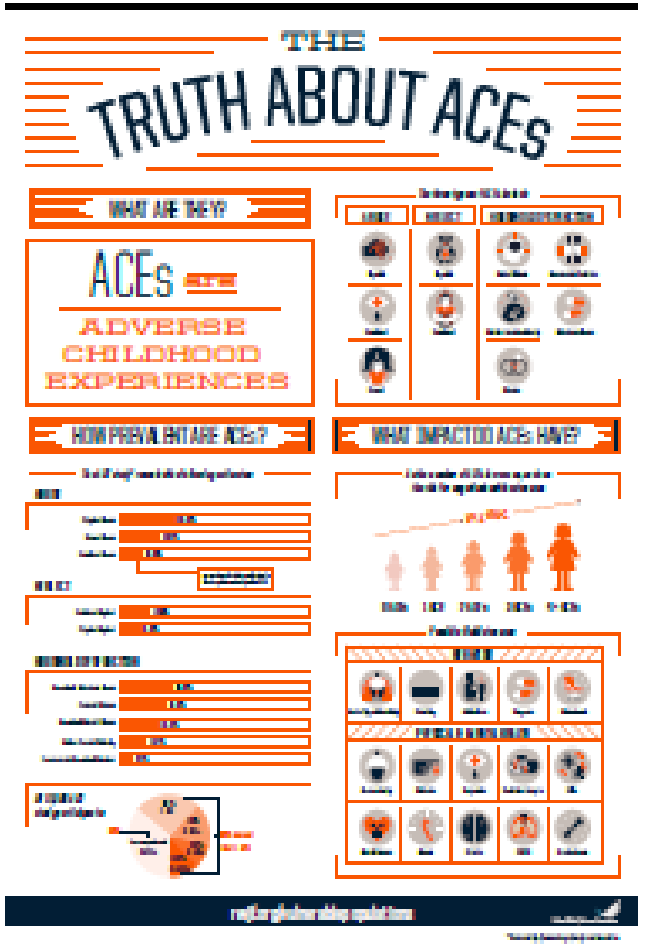
The Adverse Childhood Experiences Study

Authors: Drs. Robert Anda and Vincent Felitti

N=17,421 adults who were having medical difficulties received a survey about their childhood experiences

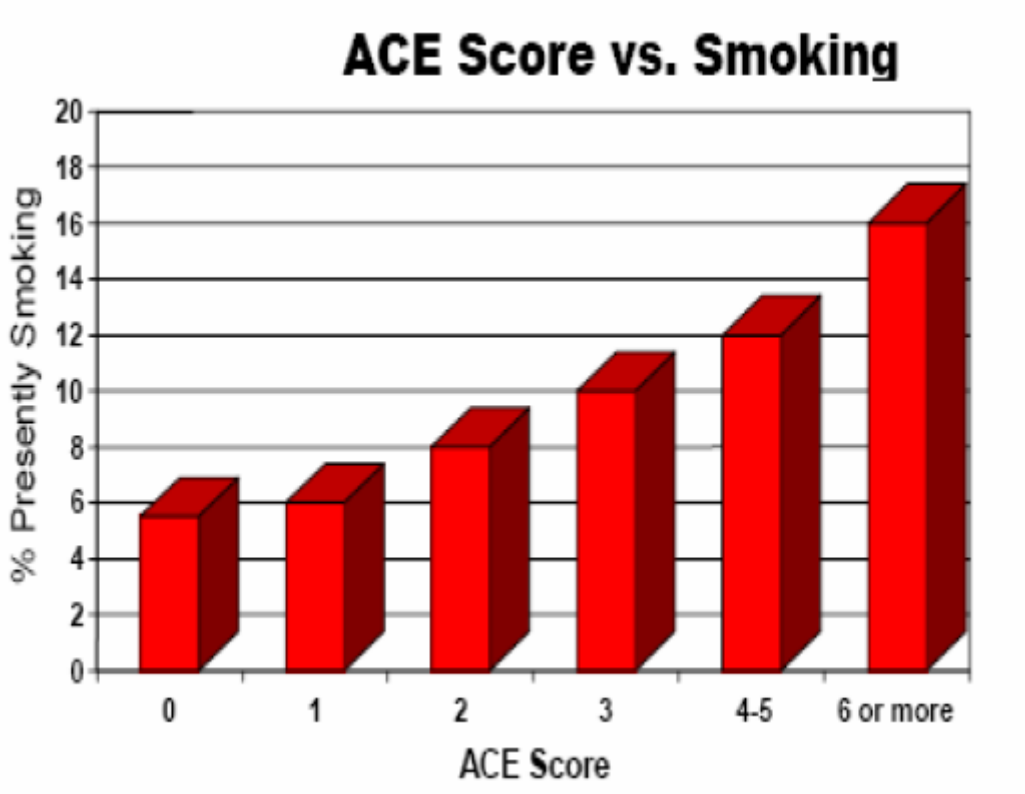
9 categories of adverse childhood experiences were examined

A person's ACE score is sum of the number of categories a person experienced



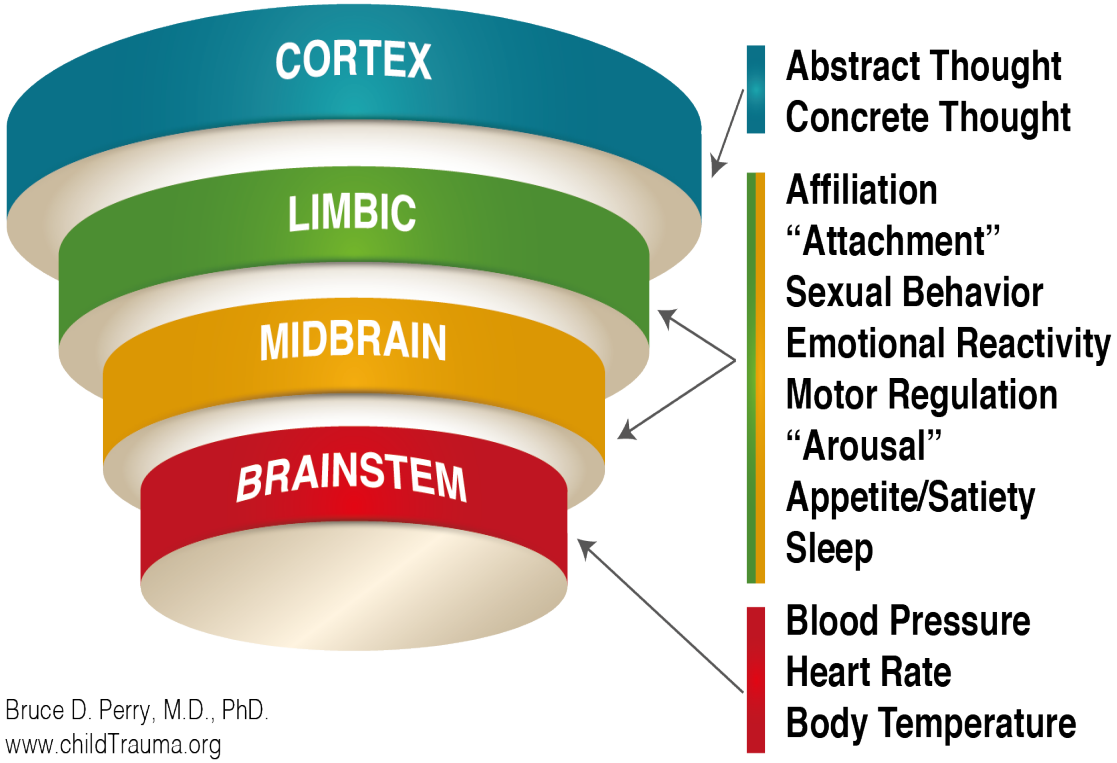
ACE Scores Are Related To Health

- Adolescent Health
- Teen pregnancy
- Sexual abuse
- Risk of re-victimization
- Smoking
- Alcohol use disorders
- Illicit drug use disorders
- Mental health
- Relationship stability
- Workforce performance



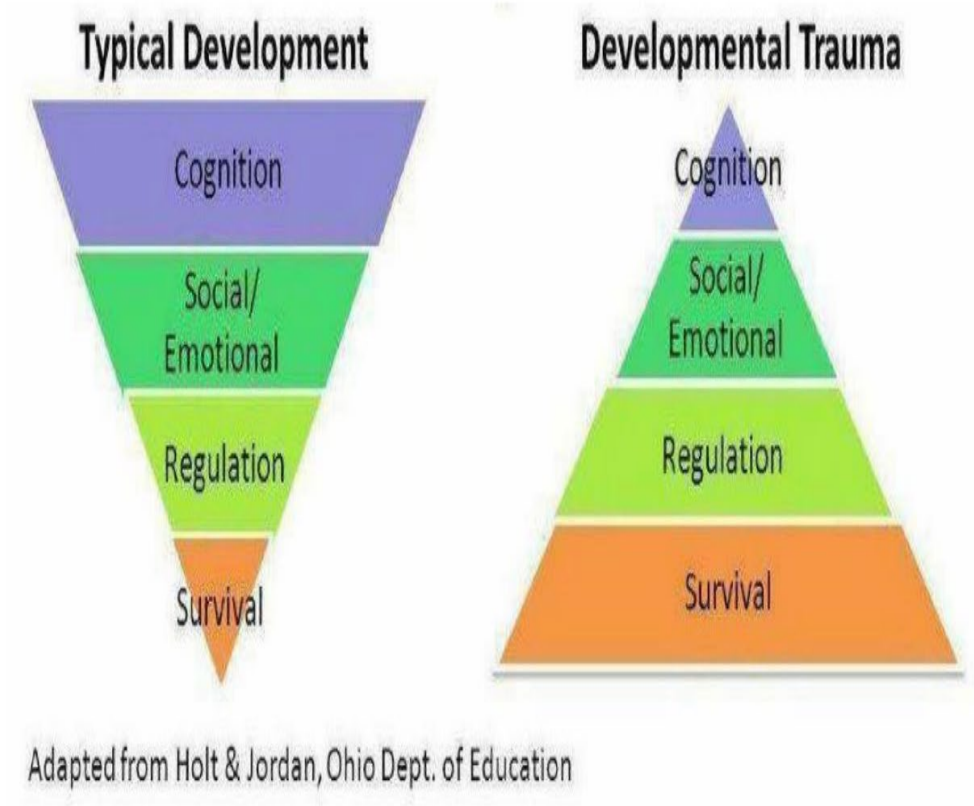
The Brain and Trauma

The brain has a “bottom-up” organization

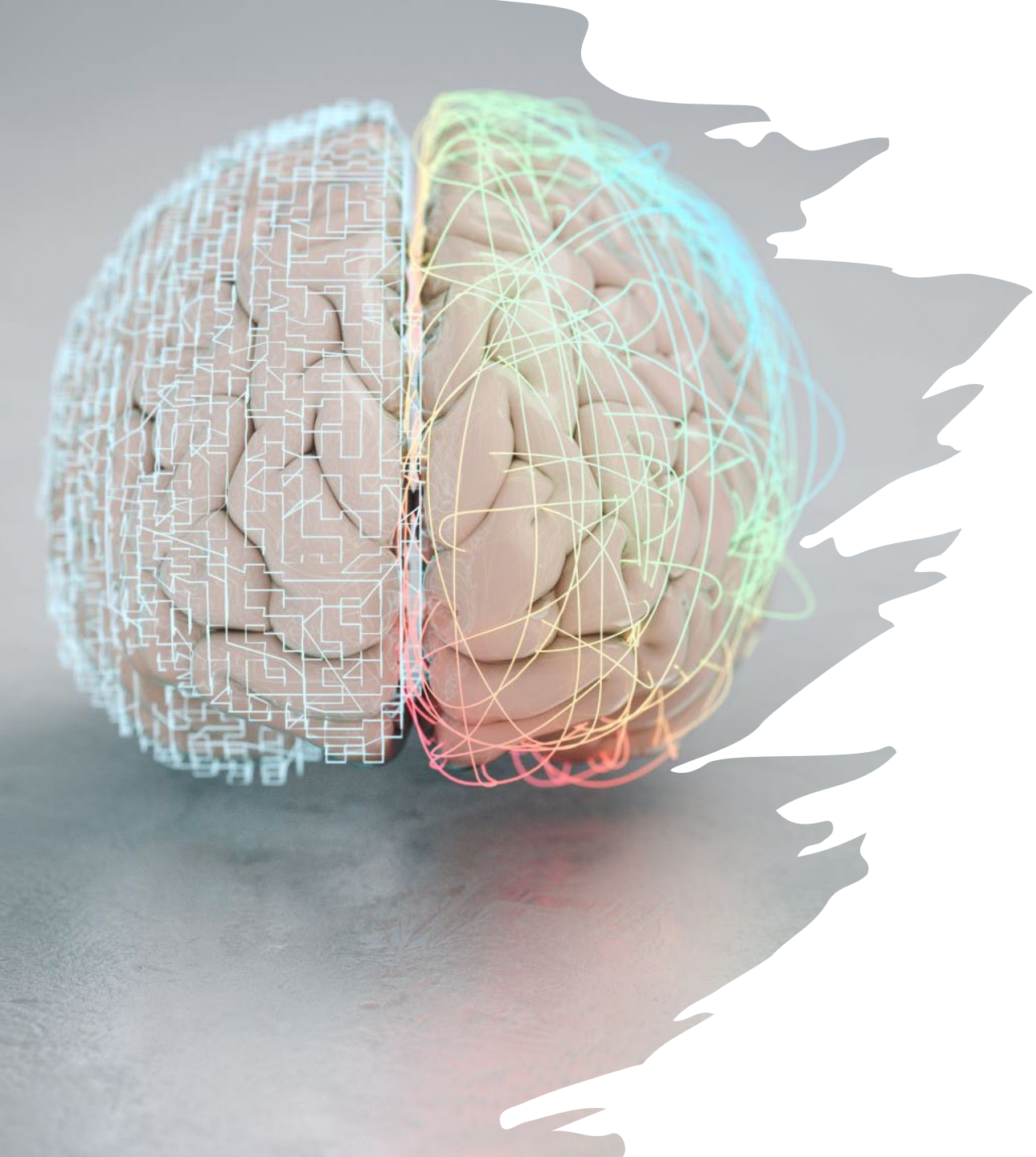


Bruce D. Perry, M.D., PhD.
www.childTrauma.org

Trauma & Brain Development



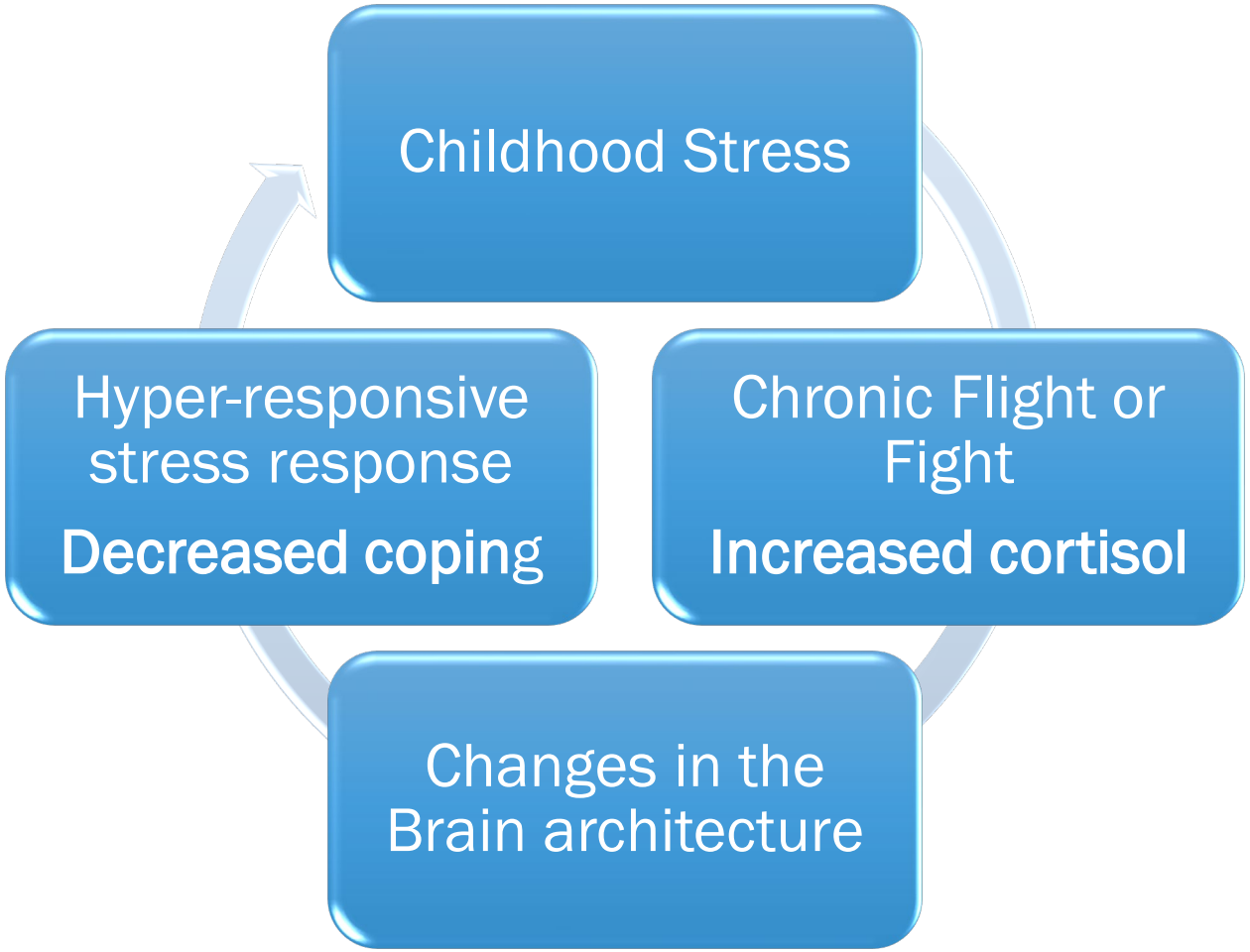
Adapted from Holt & Jordan, Ohio Dept. of Education



The Brain and Trauma: Modified by Experience

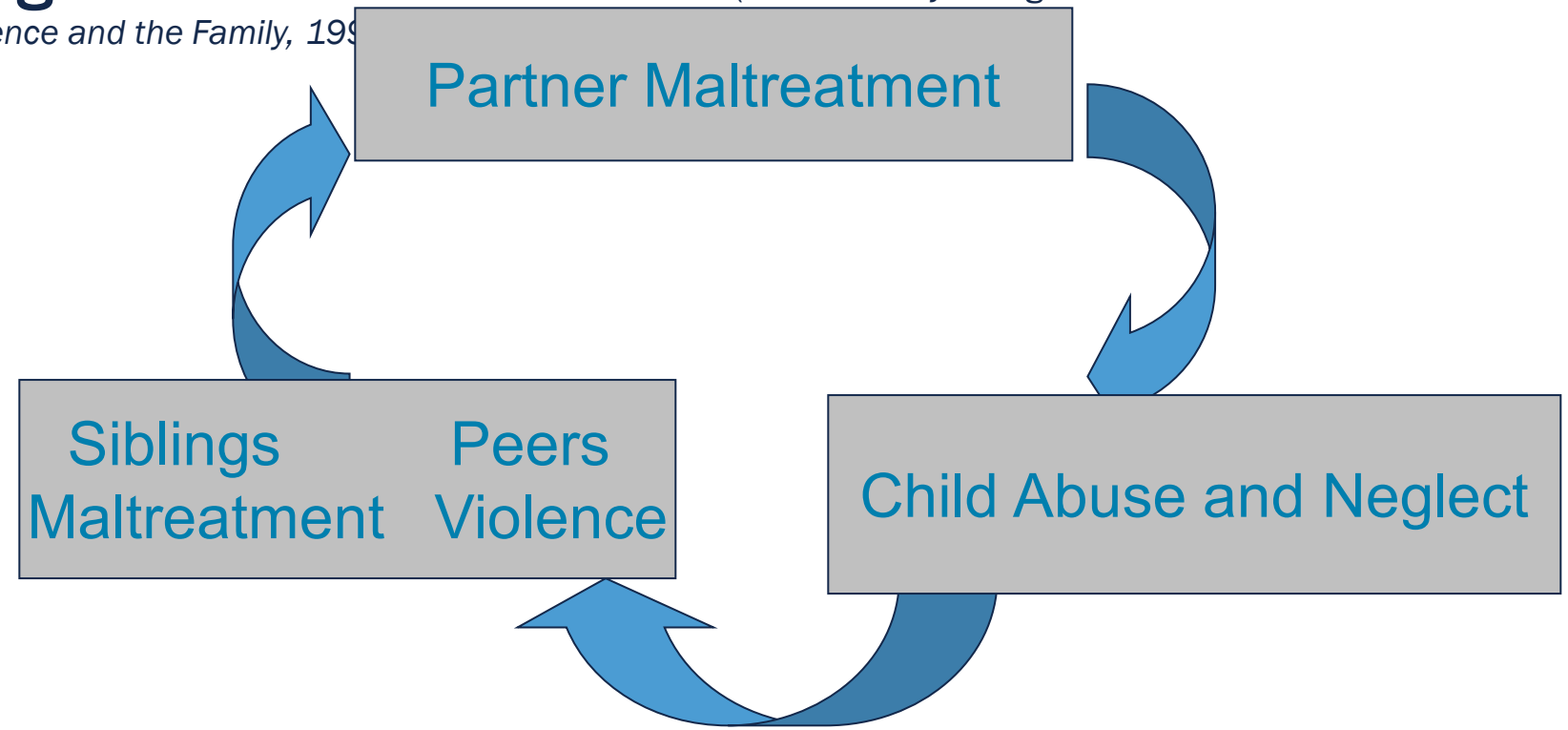
- The more a neural system is activated, the more it will "build-in" this neural state
- What occurs in this process is the creation of an "internal representation" of the experience corresponding to the neural activation
- This "use-dependent" capacity to make an "internal representation" of the external or internal world is the basis for learning and memory
- The result of this sequential neurodevelopment is that the organizing, "sensitive" brain of an infant or young child is more malleable to experience than a mature brain

Impact of Early Stress



Interpersonal Violence: Intergenerational Cycle of Violence

"A child's exposure to the father abusing the mother is the strongest risk factor for transmitting violent behavior from one generation to the next." (*American Psychological Association Presidential Task Force on Violence and the Family, 19*



Protective Factors Against Trauma

Dr. Bruce Perry's Six Core Strengths for Children: A Vaccine Against Violence

ATTACHMENT: being able to form and maintain healthy emotional bonds and relationships

SELF-REGULATION: containing impulses, the ability to notice and control primary urges as well as feelings such as frustration

AFFILIATION: being able to join and contribute to a group

ATTUNEMENT: being aware of others, recognizing the needs, interests, strengths and values of others

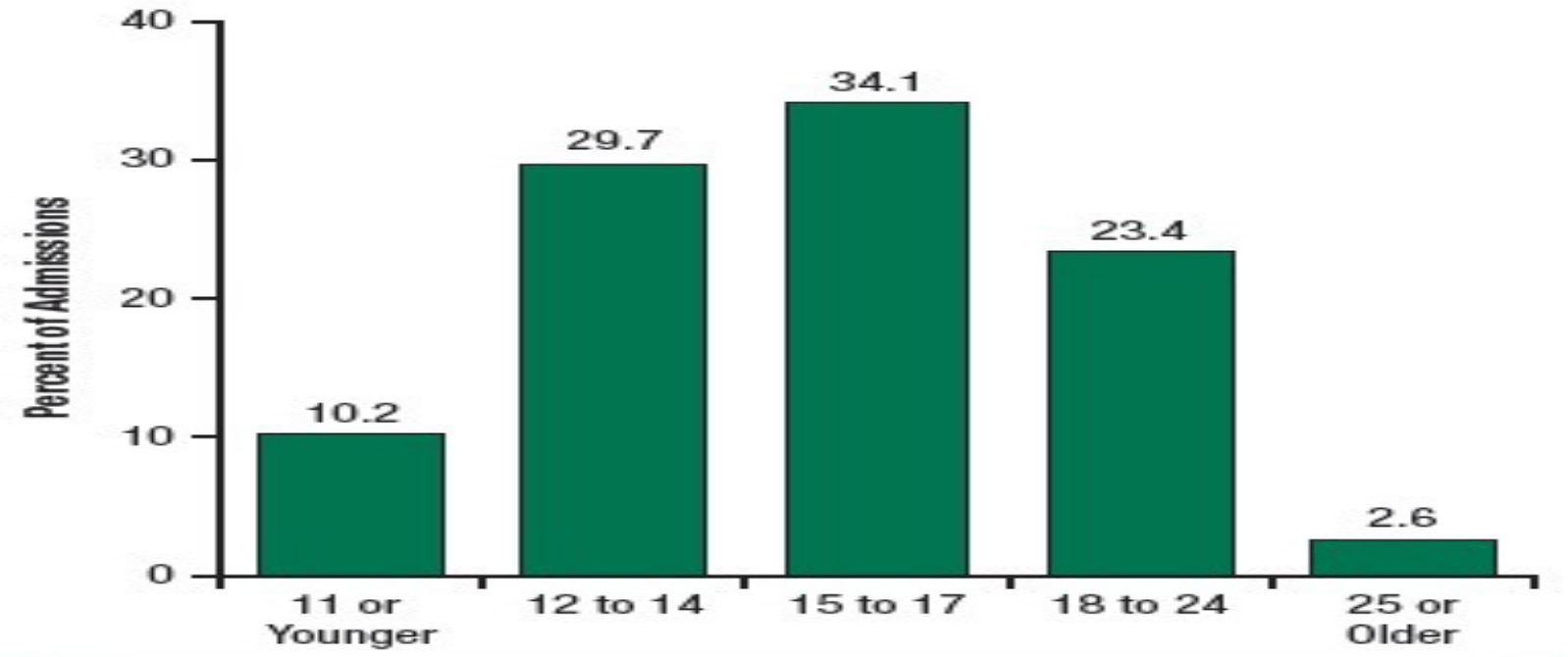
TOLERANCE: understanding and accepting differences in others

RESPECT: finding value in differences, appreciating worth in yourself and others

For more information on the Six Core Strengths, visit the "Meet Dr. Bruce Perry" page at http://teacher.scholastic.com/professional/bruceperry

Substance Use Disorders are Pediatric Illnesses

Just 5 percent of youth with a substance use disorder get treatment



http://www.samhsa.gov/data/client-level-data-teds

Trauma-Responsive Care

A definition of trauma-informed approach incorporates three key elements:

(1) Realizing the prevalence of trauma

(2) Recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce

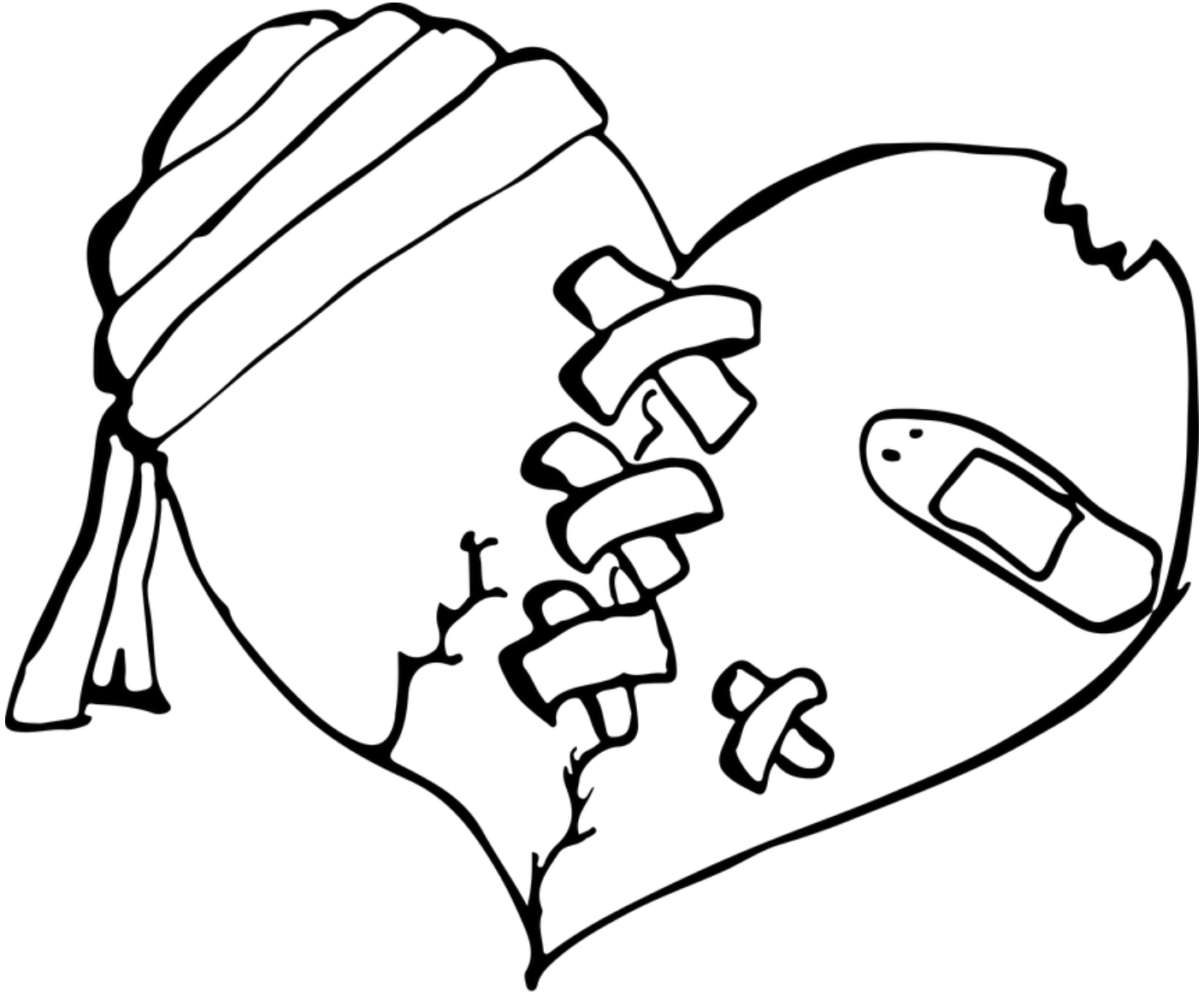
(3) Responding by putting this knowledge into practice

How to Identify Trauma Triggers

Triggers of Trauma

- Sights
- People
- Places
- Sounds
- Smells
- Tastes
- Thoughts
- Things

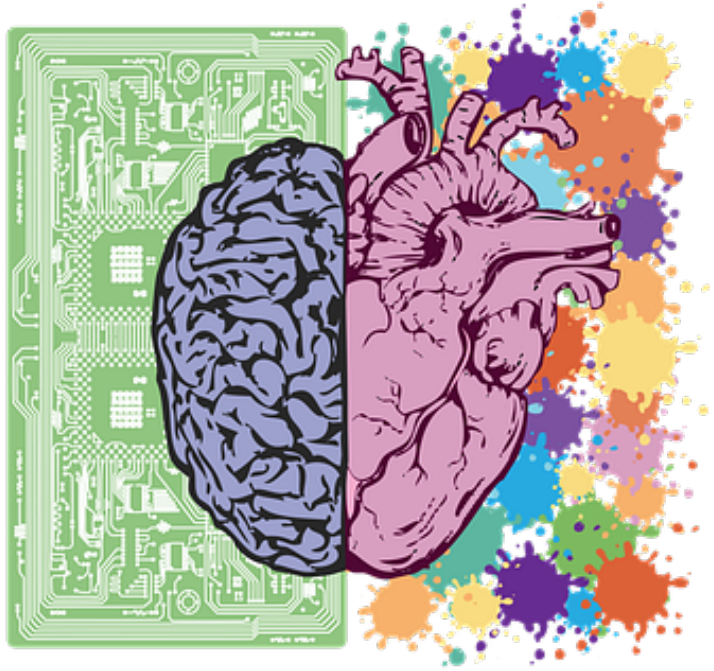
- *Some triggers are obvious and some are not*



How Do You Develop Triggers?

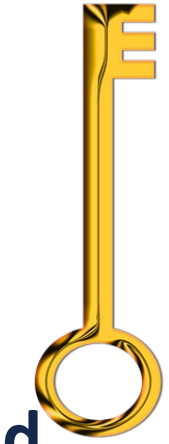
- When faced with danger, your body gets ready to fight, flee, or freeze
- Your heart beats faster
- Your senses go on high alert
- Your brain stops some of its normal functions to deal with the threat
- This includes your short-term memory

The Brain Does Not Process Trauma As The Past



- The brain doesn't file the memory of the event as being in the past.
- The result: You feel stressed and frightened even when you know you're safe
- The brain attaches details, like sights or smells, to that memory
- These become triggers. They act like buttons that turn on your body's alarm system.
    - When one of them is pushed, your brain switches to danger mode.
    - This may cause you to become frightened and your heart to start racing.
    - The sights, sounds, and feelings of the trauma may come rushing back.

Keys To Identify Trigger Responses



Anger or Irritability	Key to identify: overreaction
Mood	Key to identify: unexplained changes in mood
Dissociation	Key to identify: the mind's distance from the body
Anxiety	Key to identify: evaluation and control

WHAT HELPS?

Creating a Trauma-Informed environment using the following five principles:

SAFETY	CHOICE	EMPOWERMENT	COLLABORATION	TRUSTWORTHINESS
CREATING AREAS THAT ARE CALM AND COMFORTABLE	PROVIDING AN INDIVIDUAL OPTIONS IN THEIR TREATMENT	NOTICIING CAPABILITIES IN AN INDIVIDUAL	MAKING DECISIONS TOGETHER	PROVIDING CLEAR AND CONSISTENT INFORMATION

Simpson, R. & Green, S.A. (2014). Adapted from: Fallot, R.D & Harris, M. (2001). Using trauma theory to design service systems: New directions for mental health services. Jossey-Bass: San Francisco, CA, Jennings, A. The Anna Institute, National Council for Community Behavioral Healthcare. Is your organization trauma-informed?

What is Safety?

- Achieve abstinence from substances
- Eliminate self-harm
- Acquire trustworthy relationships
- Gain control over overwhelming symptoms
- Attain healthy self-care
- Remove oneself from dangerous situations (such as domestic violence, unsafe sex)
- *Seeking Safety:* Lisa Najavits

Ways To Create and Nurture Safety

“You’re not bad, you’re not sick. You’re injured.”

Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.” (SAMHSA)

A strength-based approach and a cultural shift to appreciate/respond to each person’s set of circumstances and needs – “**meeting where they are”,** when and where they need it.

Ways To Create and Nurture Safety

Changing the conversation from "what is wrong?" to "what happened?"

Examples:

"What is wrong with this woman… how could she use drugs during pregnancy?"

→**"I wonder what happened to this woman to affect her life this way and the impact it has had on her health and pregnancy?"**

"How can she use drugs and call herself a mother?"

→**"I can appreciate the vulnerability and the courage she has to reach out for help and to talk about drug use."**

Ways To Create and Nurture Safety- Explore Internal Bias and Opportunities

- Recognize trauma as part of “escalating” or “difficult” behaviors
- Recognize judgment, shame and traumatic childbirth
- Offer comforting and positive regard
- Embrace a whole-person trauma-informed approach

Provider magic wand: courage and kindness!

- Evaluate your role as a provider
- Reflect on your role as a healer and what you bring to the interaction
- Internal bias towards substance use and vulnerability: past experience, race, religion, secondary trauma

Create and Nurture Safety- Use Person First Recovery Language

Instead of...	Use...	Because...
• Pregnant opiate addict • Addict • User • Substance or drug abuser • Junkie	• Pregnant woman with an OUD • Person with substance use disorder[1] • Person with OUD or person with opioid addiction (when substance in use is opioids) • Patient • Person in active use; use the person's name, and then say "is in active use."	• Person-first language helps to focus on the person and not their disorder. While they may have history of substance use, it is not their only identity.[18] • The change shows that a person "has" a problem, rather than "is" the problem.[21] • The terms avoid eliciting negative associations, punitive attitudes, and individual blame.[21]
• Alcoholic • Drunk	• Person with alcohol use disorder • Person who misuses alcohol or engages in unhealthy/hazardous alcohol use	Same as above.
• Bad influence	• Person who has had many life challenges	Same as above.
• Former addict • Reformed addict	• Person in recovery or long-term recovery • Person who previously used drugs	Same as above.

https://www.drugabuse.gov/sites/default/files/nidamed_words_matter_women_infants_families.pdf

Create and Nurture Safety- Use Person First Recovery Language

Instead of...	Use...	Because...
• Slip • Lapse • Relapse	• A return to use	Same as above.
• Addicted baby • Neonatal abstinence syndrome (NAS) baby • Crack baby	• Baby born to mother who used drugs while pregnant • Baby with signs of withdrawal from prenatal drug exposure • Baby with neonatal opioid withdrawal/NAS • Newborn exposed to substances	• Babies cannot be born with addiction because addiction is a behavioral disorder; they are simply born manifesting a withdrawal syndrome. • Clinically accurate, non-stigmatizing terminology should be the same as would be used for other medical conditions.[22] • Using person-first language can reduce stigma.[18]
• Habit	• Substance use disorder • Drug addiction	• "Habit" inaccurately implies that a person is choosing to use substances or can choose to stop.[2] • "Habit" also dismisses and undermines the seriousness of the disease.
• Abuse	**For prescription medications:** • Misuse • Used other than as prescribed • Diverted • Self-medicating **For illicit drugs and other substances:** • Use	• The term "abuse" was found to have a high association with negative judgments and punishment.[23] • "Legitimate use" of prescription medications is how the medications are prescribed to be used. Any consumption outside these parameters is "misuse."

https://www.drugabuse.gov/sites/default/files/nidamed_words_matter_women_infants_families.pdf

Create and Nurture Safety- Use Person First Recovery Language

• Opioid substitution or replacement therapy • Medication-assisted treatment (MAT)	• Opioid agonist therapy • Pharmacotherapy • Addiction medication • Medication for a substance use disorder • Medication for opioid use disorder (MOUD)	• MOUD is medication for an illness that does not produce euphoria when used as directed. • It is a misconception that medications merely "substitute" one drug or "one addiction" for another.[2] • The term MAT implies that medication should have a supplemental or temporary role in treatment. Using "MOUD" aligns with the way other psychiatric medications are understood (e.g., antidepressants, antipsychotics), as critical tools that are central to a patient's treatment plan.
• Clean	**For toxicology screen results:** • Testing negative • Drug free **For non-toxicology purposes:** • Being in remission or recovery • Abstinent from drugs • Not drinking or taking drugs • Not currently or actively using drugs	• Clinically accurate, non-stigmatizing terminology should be the same as would be used for other medical conditions.[22] • It is important to set an example with your own language when treating patients who might use stigmatizing slang. • Use of such terms may evoke negative and punitive implicit cognitions.[21]
• Dirty	**For toxicology screen results:** • Testing positive **For non-toxicology purposes:** • Person actively using substances	• Clinically accurate, non-stigmatizing terminology should be the same as would be used for other medical conditions.[23] • Such terminology may decrease patients' sense of hope and self-efficacy for change.[21]

https://www.drugabuse.gov/sites/default/files/nidamed_words_matter_women_infants_families.pdf

Examples of Choice, Empowerment and Collaboration: Trauma-Informed Health Care Practices

- Before the appointment
- In the waiting room
- In the office or exam room
- After the appointment

Trauma-Responsive Care: Principles

- Respect trauma as a central concern in a woman's life
- Symptoms are adaptations to traumatic experiences
- Reframe 'Adaptive' behavior as positive coping
- Violence and trauma have broad impact
- Providers need to meet the woman where she is in her life experience

Trauma-Responsive Communication

Whole person focus and collaborative interpersonal relationship

Compassionate rapport-building: listen, respect, support/validate, give space/time, assist

- **Awareness:** Appreciate the role of trauma
- **Safety:** Place priority on physical and emotional safety
- **Trustworthiness**: Optimizing trustworthiness and maintaining boundaries
- **Choice:** Respect autonomy
- **Collaboration/Empowerment:** Inspiring empowerment and skill-building

Let's Take a Journey – While Seeking Care

Non-Compassionate Language

- "If you don't make your appointment, we may have to terminate you as a patient."
- "Can you complete this SUD screening tool?"
- "I've worked in this area for some time, and I feel comfortable with working with you."
- "Here's what we're going today"

Compassionate Language

- "I noticed that you were unable to make your last few appointments, is there anything the office can do to support you?"
- We have some forms that we would like for you to fill out, based on your answers, here are some next steps – You are not alone!"
- "I want to hear from you and how you envisioned your pregnancy or birthing experience to look like."
- "Can you tell me what I can do to help you feel safe here."

Trauma Responsive Conversations and Opportunities

“I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.”

-Dr. Maya Angelou

How do we create a trauma-responsive culture in our clinical practices?

Addiction treatment during pregnancy

Clinical wisdom pearl:

Compassion and person-centered care goes beyond being non-judgmental; they necessitate intentionality to integrate respect, kindness and 'treating people as people'

The birth hospitalization

Clinical wisdom pearl:

We will never understand what it means to walk in someone else's shoes; empathy requires we accept this and consistently strive to try to do so

Care through the postpartum period

Clinical wisdom pearl:

Maintaining compassion and a person-centered approach requires ongoing humility, self-reflection and never-ending desire to use feedback to better oneself as a provider

Addiction treatment during pregnancy

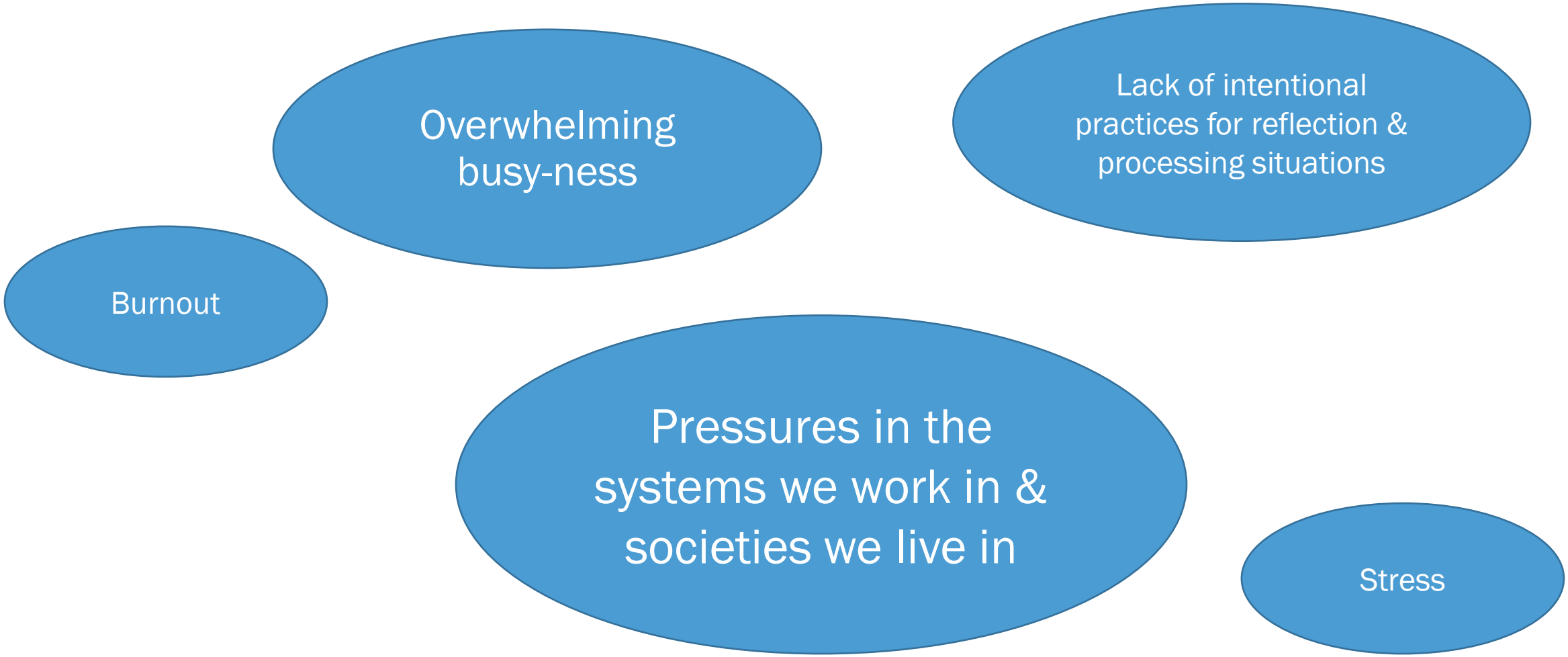
Christine is a 28-year-old G2P1 at 35 weeks gestation with stimulant use disorder. She established prenatal care at 21 weeks. She had an appointment scheduled at 19 weeks, but she missed it; she called back at 21 weeks to reschedule. The clinic care team was able to get her into a recently canceled appointment slot that week as well as get the ultrasound suite to overbook a slot for her to do her anatomy ultrasound. She was instructed to arrive early to go to the lab to draw her initial prenatal labs before her provider appointment. Christine arrived 30 minutes late to her appointment. Her provider saw her, and the ultrasound suite squeezed her in, but their schedules for the rest of the clinic day were thrown off making them both running behind to see other patients. At that appointment, the nurse connected Christine with a behavioral health clinician for ongoing group and individual therapy addressing her stimulant use disorder and co-morbid generalized anxiety disorder. The counselor called her at the scheduled telehealth intake appointment, but Christine did not answer. Christine called the clinical coordinator 2 hours later asking for the appointment to be rescheduled; the coordinator was not able to find another new patient intake appointment for a few weeks as they were all booked with other patients expressing to the coordinator they would like earlier appointments as they become available, eager to start behavioral health treatment. Christine returned to clinic for her 25-week appointment where she was counseled on the importance of returning at 28 weeks as that prenatal appointment incudes additional testing, such as the glucose tolerance test and repeat labs. The social worker assisted Christine with setting up transportation for this appointment by calling the transportation service herself with the patient also on the line. However, Christine missed her 28-week appointment. The team nurse called the patient after she missed her appointment, to get her rescheduled and assess for any pregnancy concerns. Christine did not answer the phone. Christine called the general clinic line at 35 weeks asking the scheduler for a rescheduled appointment.

How would you react when caring for this patient in the midst of your busy day?

We can easily find ourselves frustrated as we see the patient ‘check-in time’ pop up on the EMR 30 minutes into the delicately crafted schedule your team made.

The team, out of concern for Christine, reached out to help her, adding additional tasks. Then Christine did not take advantage of the set-up transportation or the new appointment made for her.

Challenges to promoting compassion and person-centeredness



An ‘in the moment’ technique to be intentional in promoting compassion & person-centered communication

- STOP
- PAUSE
- VISUALIZE THE WEB

“As a nurse, I have found myself disappointed and/or frustrated when a pregnant person with a substance use disorder readily engages over the phone with me, explaining their medical and substance use history in detail but then do not follow through with many, or any, clinic appointments provided.”

- Marjorie Scheikl, RN MSN, Perinatal Addiction Program Manager

An ‘in the moment’ technique to be intentional in promoting compassion & person-centered communication

- STOP
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”Putting on a wider lens, has helped me “see” that my disappointment stems from my own desire as a nurse for all pregnant women to receive complete and ‘on time’ prenatal care. The patient has their own priorities, needs, and desires. I had to accept, and celebrate even, that a patient chose to engage with me, a nurse (an unknown person), over the phone. I was given the opportunity to help a person through active listening, answering patient questions…If or when the patient feels ready to go beyond a phone call, the patient has our clinic phone line to call.”

- Marjorie Scheikl, RN MSN, Perinatal Addiction Program Manager

An ‘in the moment’ technique to be intentional in promoting compassion & person-centered communication

- STOP
- PAUSE
- VISUALIZE THE WEB

VISUALIZE a diagram of the factors that led to the situation beyond the individual level

Individual level: Depression impeding patient's energy & motivation to leave

Interpersonal level: Not having post-school childcare show up on time for a 3:30 appointment

Community level: Living in a geographic area with limited transportation & unsafe neighborhoods

Societal level: Avoiding clinic appointments to avoid being judged for not being a 'good mom'

When you intentionally visualize the complexity of these socioecological factors your patient is tackling, you can turn your perspective from ‘what is wrong with you?’ to ‘what led to what you are dealing with today?’

"I've had pregnant and parenting patients with a substance use disorder arrive late to appointments who explained circumstances such as : a) feeling the desire to feed their newborn in the NICU so that CPS would not think they were an unfit parent , before walking a few miles in the snow just 5 days after giving birth, from the hospital to the clinic , b) driving the only car they had -which did not have tags- and risking being pulled over , c) having an active arrest warrant out for them , d) being newly placed into a victim witness program and e) feeling so ill that standing was difficult which turned out to be sepsis requiring surgery and an extended hospital stay. People have reasons for not making it to an appointment 10 min early and the clinical team has an opportunity to recognize the challenges that the patient had to overcome to attend that day.

What did the patient need to arrange with family, transportation, or work to come to the clinic?

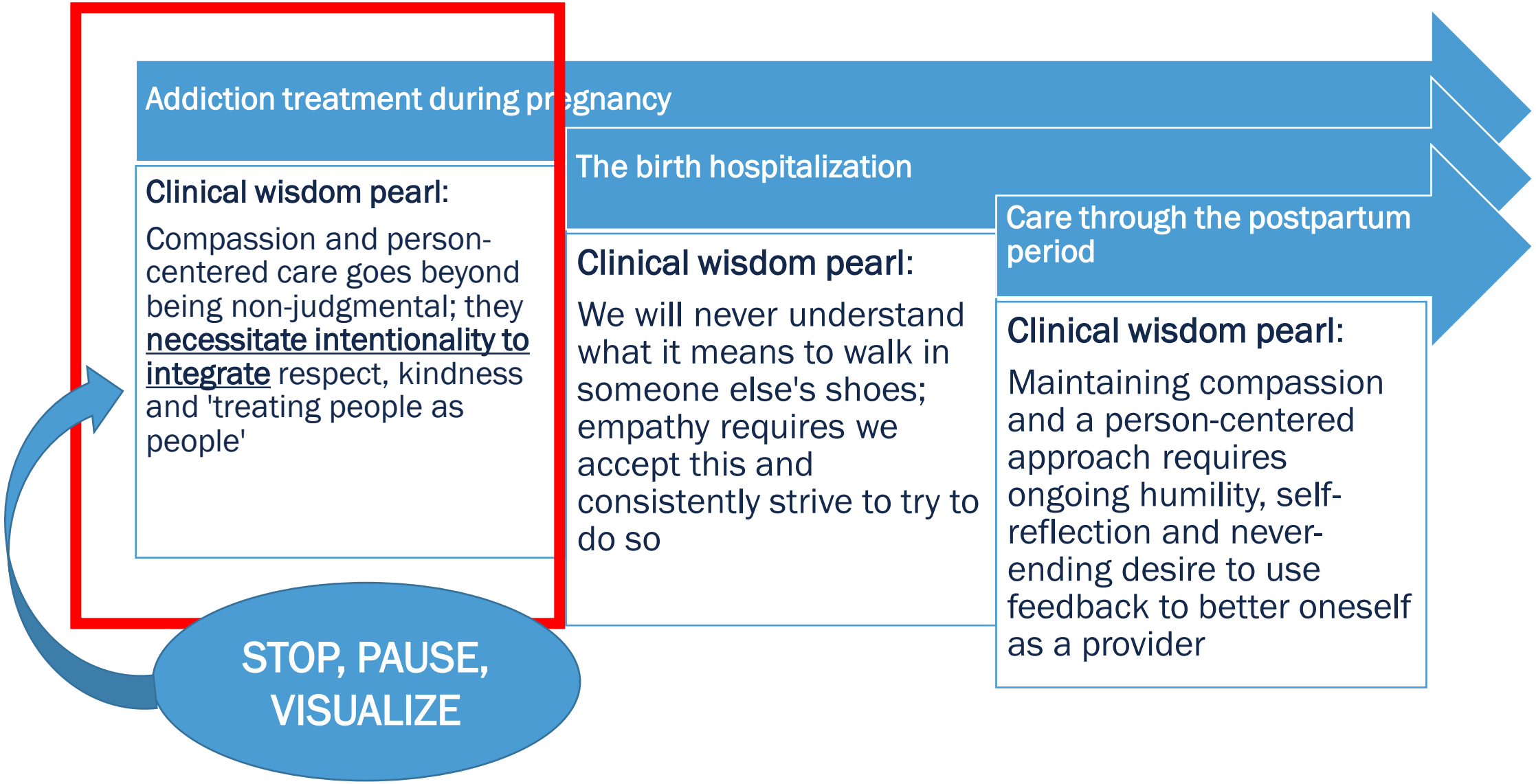
What current fears or past traumas might the patient have had to overcome to show up?

Who is with the patient, and is that person supportive?

Research indicates that persons with substance use disorders have changes to their executive functioning capacity (prefrontal cortex) such that advanced planning and organizational tasks become difficult. Considering a patient's individual circumstances and what the patient had to navigate in order to engage with the clinical care team places the "lateness" into context."

-Marjorie Scheikl, RN MSN, Perinatal Addiction Program Manager

How do we create a Trauma-Responsive culture in our clinical practices?



Potential for Vicarious Traumatization and Secondary Traumatic Stress

- Vicarious trauma is a process of change resulting from empathetic engagement with trauma survivors.

- Secondary traumatic stress (STS) refers to a set of psychological symptoms that mimic post-traumatic stress disorder, but is acquired through exposure to persons suffering the effects of trauma.

Dr Katie Baird & Amanda C. Kracen (2006) Vicarious traumatization and secondary traumatic stress: A research synthesis, Counselling Psychology Quarterly, 19:2, 181-188

Practice
Try These Out Yourself

- BELLY BREATHING - DIAPHRAGMATIC BREATHING RELAXATION/Progressive/Autogenic/Visualization
- WILLING HANDS - Marsha Linehan
- POWER POSE - Amy Cuddy
- MEDITATION/MINDFULNESS - Jon Kabat-Zinn

Practice Smile

- “SMILING IS YOGA FOR THE MOUTH” - THICH NHAT HAHN
- Paul Ekman’s research on facial expression - a smile produces a change in brain activity and creates a happier mood.
- Kraft and Pressman study - a smile can alter stress response. It can slow heart rate and decrease perceived level of stress.

Attention Matters

- Pay attention to good things, large and small
- Pay attention to bad things that are avoided
- Practice downward comparisons- remembering sorrows sweeten present joy
- In hard times, be grateful for what you have
- Elicit and reinforce gratitude in those around you

Energy Snack

- Exercise Break!
- ‘Sitting is the new smoking’ - Sitting for too long increases your risk of dying early
- Please stand up and slowly twist side to side with arm movement.
- If sitting is better for you, you can do arm and/or shoulder rolls

When to Seek Help Beyond Self-Care

suicidal

overwhelmed or can't cope

feel bad about yourself all the time

self-harming (cutting/burning)

feeling anxious all the time

When you are feeling sad or depressed all the time
When you feel helpless and hopeless

Continued

- Find a therapist or join a support group. Find one at: https://groups.psychologytoday.com/rms
- National Suicide Prevention Lifeline: 1-800-273-8255
- SAMHSA help line: 1-800-662-HELP (4357)

Free Mobile Apps for Self-Care

- CALM • Meditation
- HEADSPACE • Mindfulness
- STRIDES • Habit Tracker
- MYFITNESSPAL • Health
- GRATEFUL • Gratitude journal

Summary of Objectives

1. Identify at least three ways that trauma-informed principles can be applied in trauma-responsive practices
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