Providing Trauma Informed Care: Understanding Core Elements & Interventions for Building a Community of Support

Henry Benson, Ph.D.

Northeast Florida State Hospital

Henry_Benson@dcf.state.fl.us

Objectives

Participants will be able to describe :

- Concept of complex trauma
- Prevalence of traumatic experiences of individuals receiving public mental health services
- Neurological & biological effects of trauma
- Impact of trauma on thinking
- Effect of trauma on view of self & others
- Understanding self-injury, verbal aggression, physical aggression, & demanding behavior from a trauma informed perspective
- Defined elements of trauma informed care; safety, trustworthiness, choice, collaboration, and empowerment
- Use of comfort rooms as a therapeutic tool
- A cognitive model of patient aggression
- The patient's perspective, understanding retraumatizing situations
- Limit-setting styles
- Interventions for creating a safe environment
- Escalation Avoidance Summary and Evaluation (EASE)

Trauma and Complex Trauma

Trauma can refer to a single event such as an accident, assault, or witnessing a violent act. Trauma can also refer to repeated experiences such as repeated physical, sexual, or emotional abuse, or witnessing ongoing domestic violence.

Trauma and Complex Trauma

"We define **complex psychological trauma** as resulting from exposure to severe stressors that

(1) are repetitive or prolonged,

(2) involve harm or abandonment by caregivers or other ostensibly responsible adults,

(3) occur at developmentally vulnerable times in the victims life such as early childhood or adolescence (when critical periods of brain development are rapidly occurring)". (Ford and Courtois, 2009)

The Degree of Impact That Trauma Can Have on the Individual

- Individuals can differ in how severely they are affected by a traumatic event.
- Trauma can have a pervasive and sometimes permanent effect on a person.
- Individuals with more severe trauma, more frequent trauma, and more types of trauma are more likely to experience a devastating impact from it.
- Trauma experienced during childhood in combination with neglect during childhood is more likely to have a long lasting effect.

Adverse Childhood Experiences (ACE) Study

Kaiser Permanente's Health Appraisal Center and the Center for Disease Control and Prevention (CDC)

- Examined the effects of adverse childhood experiences across the lifespan.
- 17,337 Adult HMO members were involved.
- Different categories of adverse experiences were considered in the areas of abuse, neglect, and family dysfunction.

Higher ACE scores were found to be related to increased probability of:

- Emotional problems (Depression, Anxiety, and Panic)
- Health risk behaviors (Alcoholism, Street Drugs, Smoking)
- Difficulty controlling anger and risk of perpetrating violence
- Impaired Memory
- Hallucinations
- Adult disease and disability
- High health care costs
- Poor life expectancy

Anda, Felitti, Bremner, Walker, Whitfield, Perry, Dube, & Giles, 2006; Felitti, 1998

Suicide

- There is a significant relationship between childhood sexual abuse and various forms of self-harm later in life, including suicide attempts, and cutting.

  Van der Kolk et al, 1991

- Adult outpatients who reported a history of childhood sexual abuse or childhood physical abuse were more likely to have attempted suicide. Read, Agar, Barker-Collo, Davies, & Moskowitz, 2001

- Childhood sexual abuse was a stronger predictor of suicidality than a current diagnosis of depression. Read et al, 2001

Abuse, neglect, and the development of psychosis

- There is a significant relationship between a history of multiple childhood traumas (ACE's) and hallucinations. Anda et al 2006

- Symptoms of psychosis and schizophrenia are strongly related to childhood abuse and neglect. Read, van Os, Morrison, & Ross, 2005

- A comprehensive review of general population studies found child abuse and neglect to be significantly related to psychosis. Read, Fink, Rudegeair, Felitti & Whitfield, 2008

- A dose-response relationship has been found between experiences of multiple types of trauma and psychosis. Janssen et al. 2004; Shevlin et al., 2008

- Childhood trauma was related to functional and social impairment in adults with schizophrenia. Gil, Gama, de Jesus, Lobato, Zimmer, Belmonte de Abreu, 2009

Trauma and PTSD in Severe Mental Illness

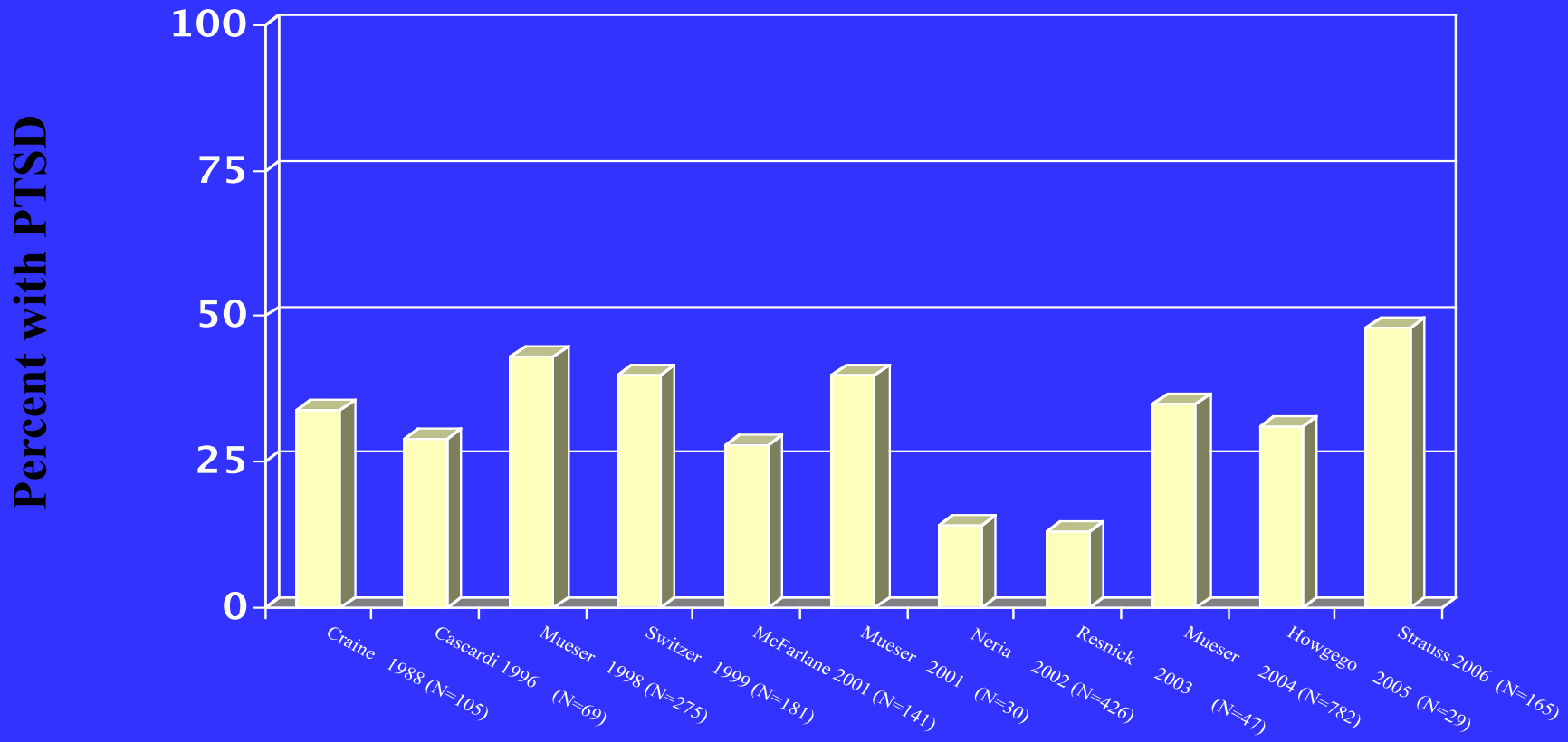
- A multiple site study found that 98% of patients with severe mental illness reported experiencing at least one traumatic event with 3.5 different traumatic events being the average. (Mueser, Goodman, Trumbetta, Rosenberg, Osher, Vidaver, Auciello & Foy, 1998)

- 43% of the sample met the criteria for PTSD but only 2% had been given the diagnosis. (Mueser et al., 1998)

- A multiple site study of 782 individuals with SMI found that 87% reported a history of physical or sexual assault and 35% met the criteria for PTSD. (Mueser, Salyers, Rosenberg, Goodman, Essock, Osher, Swartz & Butterfield, 2004)

- A **universal precautions** approach is suggested for TIC. (NASMHPD position statement on services and supports to trauma survivors, 2005)

RATES OF PTSD IN PEOPLE WITH SERIOUS MENTAL ILLNESS



Mueser, Rosenberg & Rosenberg, 2009

Prevalence

- Most clinicians were found to underestimate the prevalence of traumatic events in their patients. (Frueh, Cusack, Heirs, Monogan, Cousins & Cavenaugh, 2001)
- Failure to adequately assess for trauma may occur for a number of reasons.
- A multisite study of individuals receiving state public mental health services found 47% to have reported experiencing a DSM defined traumatic event while in the hospital. (Cusack, Frueh, Heirs, Suffoletta-Maierle & Bennett, 2003)

Effect of Traumatic Stress on Brain Development

- Traumatic stress can cause chronic changes in specific brain regions and brain circuits related to the stress response.

- Stress experienced early in development can result in a smaller hippocampus, increased amygdala functioning, and decreased prefrontal functioning.

- The result of these changes can cause an increased response to a perceived threat and an impairment in the brain's ability to extinguish the response.

(Bremner, 2006)

Consider the child's experience of trauma:

Related Functional Deficits

- Adult survivors of childhood sexual abuse were found to have deficits in **verbal declarative memory.** (Bremner et al. 2004)
- Deficits in prefrontal functioning have been shown to be related to **impulsive aggression.** (Alcazar-Corcoles et al. 2010, Bufkin et al. 2005, Wahlund et al. 2009)
- Emotional and physical neglect was significantly related to **alexithymia.** (Zlotnick et al. 2001)
- Individuals with SMI and PTSD showed higher levels of alexithymia and more severe symptoms. (Spitzer et al. 2007)
- The relationship between childhood trauma and self injury may be mediated by alexithymia. (Paivio et al. 2004, Swannell et al. 2012)

The individual experiences more intense emotion and lacks the ability to structure the experience.

The Impact of Trauma on Emotional Response

Instinctively, we need to be aware of things that can harm us.

- A traumatic event causes a strong, lasting impression, in our memory of everything associated with the event(s). This is meant to serve as an early warning system to protect us from being hurt again.

- This early warning can be activated by anything we hear, see, feel, smell and sometimes even thoughts that remind us of past trauma.

The Impact of Trauma on Emotional Response

- These early warning “Triggers” activate physical responses as if the individual is in danger of being hurt again. The individual may become confused and may feel as if they are re-experiencing the trauma. They may go into a crisis mode that is driven by intense overwhelming emotion and causes an inability to think or speak clearly.

- An individual may appear out of control because their body is responding out of control.

Changes in View of Self and Others

Individuals that have been abused repeatedly often develop a very negative view of self and others. Thoughts and experiences that contribute to this include:

- As children, trying to understand why they are being hurt, individuals may begin to believe that they must be bad and unwanted.

- Individuals may have been told by abusers and caregivers that what happened to them was their fault.

- Individuals may question how anyone could love them if even their own parents would not show them love.

- Individuals may have a strong feelings of guilt and shame about what happened and see themselves as permanently damaged or defective.

Changes in View of Self and Others

The result of this view is the expectation and anticipation that others will eventually hurt, reject, or abandon them. Individuals become defensive and aggressive to protect themselves or helpless and passive.

Trauma Informed Care

- Recognize the prevalence of traumatic experiences in the mental health population.
- Understand the significant, pervasive, and lasting impact of trauma.
- Aware of environmental and interpersonal stressors that can be re-traumatizing.
- Sensitive to the needs of individuals that have experienced trauma in their lives.

Understanding the individual's behavior involves recognizing that:
Because of what happened to them
their behaviors developed
as a way to adapt and survive
in a hostile environment.

Need to Reframe:
Understand why the behavior occurs.

• **Verbal or physical aggression**: May indicate the individual's crisis mode was activated. How much was fear a part of the response? Did the individual feel threatened (even if the threat does not seem reasonable to us)? They may feel vulnerable, or hurt. The pain from the past comes to the surface again and increases the intensity of the experience. Witnessing anger can be a very strong trigger because of memories of childhood abuse and domestic violence.

Need to Reframe:
Understand why the behavior occurs.

- **Self-injury**: Is a learned behavior, most often used as an attempt to cope with overwhelming painful and frightening emotions. Sometimes may be self-punishing. Very rarely is it simply "attention seeking" or a cry for help.

- **Demanding behavior**: May be triggered by reminders of frequent neglect they experienced during childhood. Not "spoiled" or "entitled", but the painful feeling that nobody cares.

Reframing Our Perspective of Trauma History

- Past abuse is not an excuse, but it is part of the problem. We're not making excuses for behavior, we're trying to understand the behavior.
- The accuracy of traumatic memories can be difficult if not impossible to determine. It is more therapeutic to acknowledge that the individual has experienced suffering in their life than to spend time investigating.
- Showing disbelief or denying recollections of past abuse is far more damaging than the risk of acknowledging experiences that may not be completely accurate. The denial replays scenarios from childhood in which cries for help were met with abandonment or anger.

Trauma Informed Care

- Safety
- Trustworthiness
- Choice
- Collaboration
- Empowerment

(Fallot and Harris, 2009)

Trauma-Informed Care Self Assessment Scale

from Creating Cultures of Trauma-Informed Care (CCTIC) a Self-Assessment and Planning Protocol (Fallot and Harris, 2009)

(Adapted inpatient version for Northeast Florida State Hospital December 2010)

Trauma Informed Indicators	Frequency of Occurrence

Safety	Rarely	Occasionally	Often	Consistently
To what extent do the hospital's activities and settings ensure the physical safety of individuals?				
To what extent do the hospital's activities and settings ensure the emotional safety of individuals?				
Are staff sensitive to signs of an individuals discomfort and do they understand these signs in a trauma informed way?				
Is there sensitivity to potentially unsafe situations?				
Are individuals provided with clearly defined expectations that are consistent and fair?				
Are individuals provided with explanations and rationale for expectations?				

Safety for Staff	Rarely	Occasionally	Often	Consistently
To what extent do the hospital's activities and settings ensure the physical safety of staff?				
To what extent do the hospital's activities and settings ensure the emotional safety of staff?				
Do staff members feel comfortable bringing clinical concerns to treatment teams and supervisors?				
Do staff members feel comfortable discussing the emotional effect of situations with treatment teams and supervisors?				

Safety

- Both physical and emotional safety are ensured.

- Staff are aware of potential environmental and emotional triggers.

- Sensitivity to individual's discomfort and understanding of how past experiences may be influencing current behavior.

- Clear, consistent, and fair expectations.

- Explanations and reasons for expectations are provided ("Because I said so" doesn't qualify).

(Fallot and Harris, 2009)

Trustworthiness

- Provide honesty and transparency in service delivery.
- Maintain respectful professional boundaries.
- Provide consistency in service delivery.

Choice

- Maximize experiences of choice and control.
- Provide opportunities for small choices to be made.
- Avoid arbitrary negative consequences for an individual exercising independent choice.

(Fallot and Harris, 2009)

Collaboration

- Maximize sharing of power between staff and individuals.
- Involve trauma survivors as advocates and educators.
- Give individual preferences consideration.
- Communicate respect for the individual's experiences.

Empowerment

- Prioritize empowerment and skill building.
- Recognize strengths and skills.
- Emphasize growth more than maintenance.
- Help the individual to feel valued, validated, and affirmed.

(Fallot and Harris, 2009)

Trauma Screening, Assessment, Service Planning, and Trauma Specific services

- To what extent does the hospital have a consistent way to identify individuals who have been exposed to trauma, to conduct appropriate follow-up assessments and to include trauma related information in service planning?
- Screening avoids over complication, unnecessary detail, and unnecessary repetition so as to minimize stress for individuals.
- At least minimal questions addressing physical and sexual abuse are included in trauma screening.
- Screening is followed as appropriate by a more extensive assessment of trauma history and trauma related sequelae.
- The hospital offers individual and group approaches to trauma recovery.

(Fallot and Harris, 2009)

Staff Trauma Training and Education

- To what extent have all staff members received appropriate training in trauma and it's implications for their work?
- General education has been offered for all employees with a primary goal of sensitization to trauma related dynamics and the avoidance of retraumatization.
- Staff members have received education in trauma informed understanding of unusual or difficult behaviors.
- Staff members have received training in basic coping skills for trauma survivors.
- Staff members offering trauma specific services are provided adequate support via supervision and/or consultation.

(Fallot and Harris, 2009)

Human Resources Practices

- To what extent are trauma related concerns part of the hiring and performance review process?
- Interviews with applicants include questions concerning knowledge about the impact of trauma and abuse.
- The hospital seeks to hire or identifies among current staff "Trauma Champions" who are knowledgeable about trauma, prioritize trauma sensitivity, communicate the significance of trauma and, support trauma informed changes.

(Fallot and Harris, 2009)

Administrative Support for Hospital-Wide Trauma Informed Services

- To what extent do hospital administrators support the integration of knowledge about violence and abuse into hospital practices?
- Is there a policy statement that refers to the importance of trauma and the need to account for consumer experiences of trauma in service delivery?
- Administrators are willing to attend trauma related trainings themselves.
- Administrators support the existence of a trauma initiative (workgroup, specialists).

(Fallot and Harris, 2009)

Formal Service Policies

- To what extent do the formal policies of the hospital reflect an understanding of trauma survivors needs, strengths and challenges?
- The hospital avoids involuntary or potentially coercive aspects of treatment whenever possible.
- The hospital has developed a de-escalation policy that attempts to minimize the possibility of retraumatization.
- The hospitals policies address issues related to staff safety.

(Fallot and Harris, 2009)

Effectiveness of Trauma Informed Care

- The sanctuary model, a trauma informed program, was found to decrease violence in a state hospital setting.(Bills and Bloom, 2000, 1998)
- Decreases in incidents of violence and staff injuries were shown after implementing a trauma informed program in a locked psychiatric unit. (Murphy and Bennington-Davis, 2006)
- Implementation of a trauma informed program in a Canadian psychiatric hospital found significant improvement in symptoms of PTSD, depression, and anxiety as well as improvement in goal performance. (Wright and Woo, 2000)
- Trauma informed programs have shown a decrease in trauma and mental health symptoms and an improvement in functioning. (Cocozza et al. 2005, Morrissey et al. 2005)

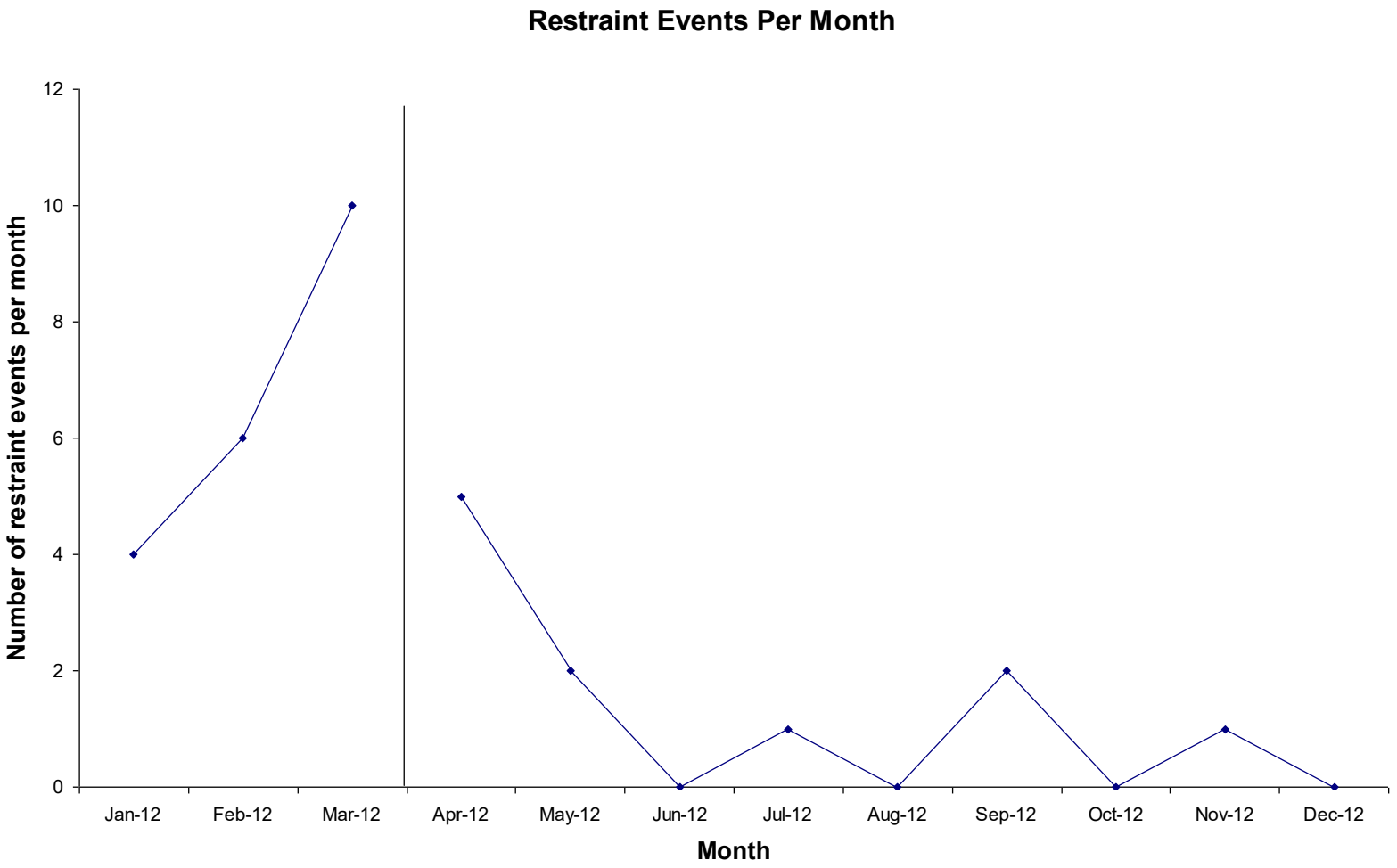
Effectiveness of Trauma Informed Care

- Women with high levels of PTSD symptoms along with alcohol and drug abuse were found to have higher levels of psychotic symptoms and showed the greatest improvement with trauma integrated care. (Cusack, Morrissey & Ellis, 2008)

- Adolescents in a trauma informed program showed greater coping skills and greater sense of control over their lives compared to youths in standard residential services. (Rivard, Bloom, McCorkle & Abramovitz, 2005)

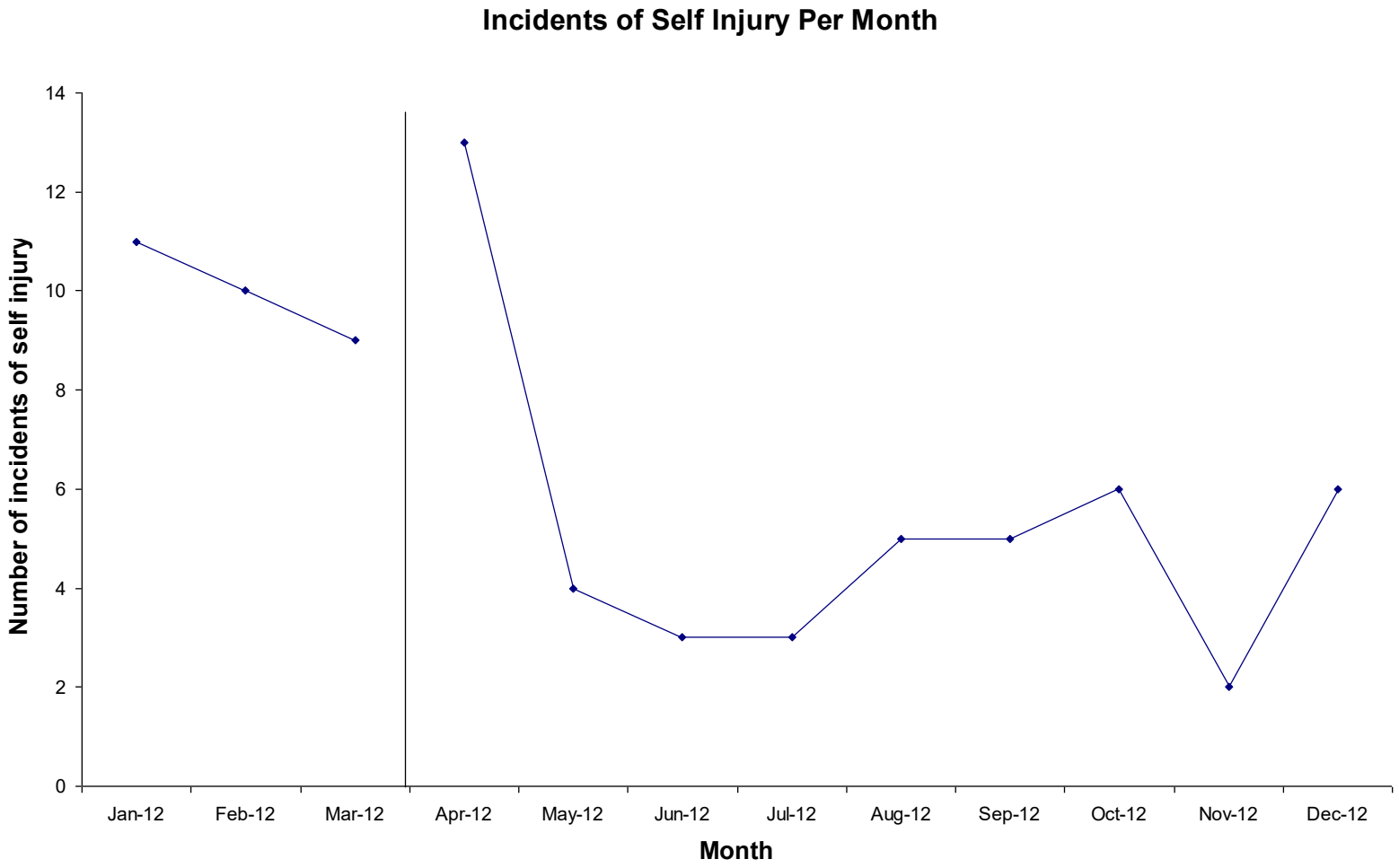
- A reduction in seclusion and restraints was found after implementing trauma informed care at a child and adolescent psychiatric hospital. (Azeem, Aujla, Rammerth & Jones, 2011)

Effectiveness of Trauma Informed Care in an Inpatient Setting



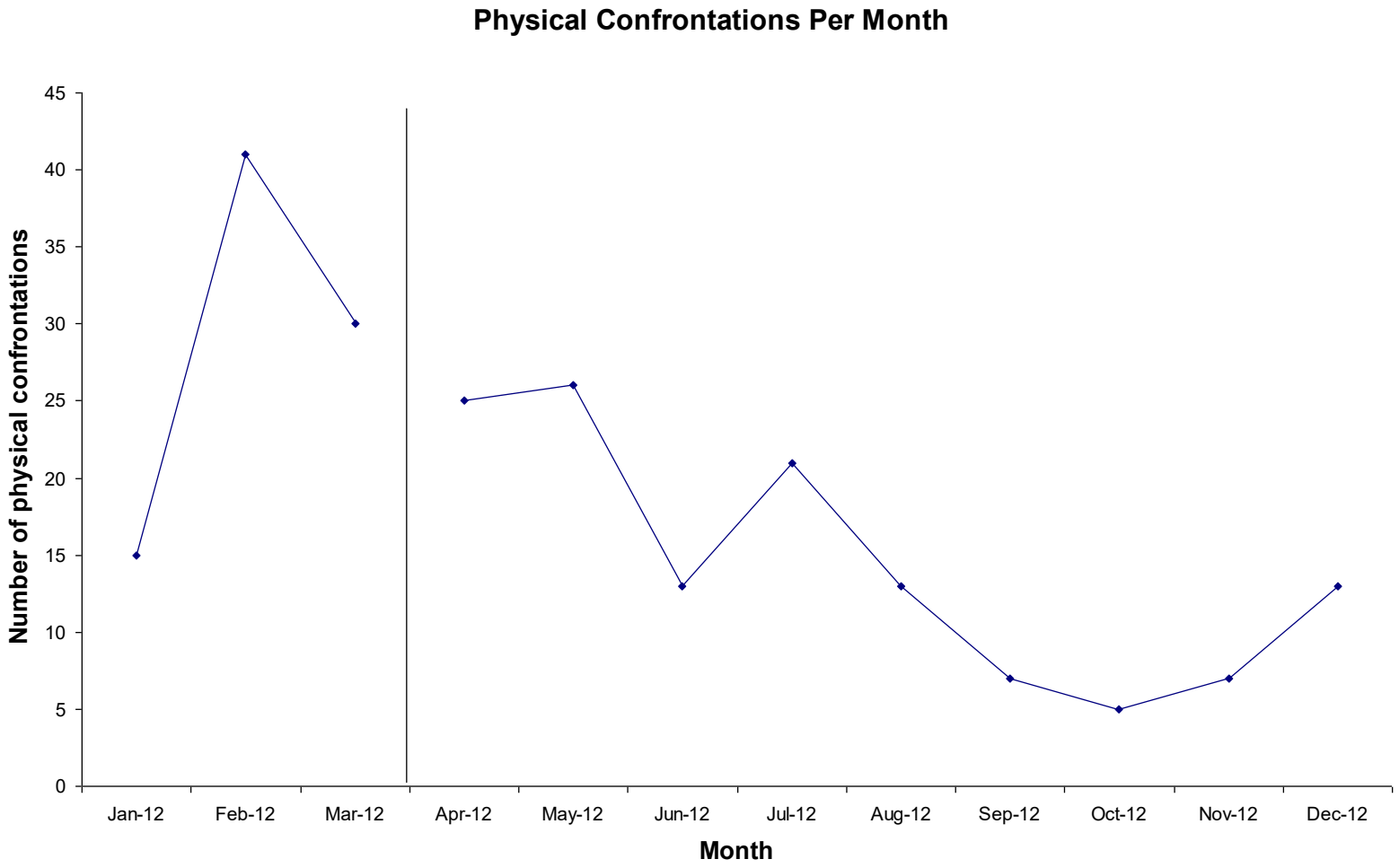
Benson, 2012 Northeast Florida State Hospital

Effectiveness of Trauma Informed Care in an Inpatient Setting



Benson, 2012 Northeast Florida State Hospital

Effectiveness of Trauma Informed Care in an Inpatient Setting



Benson, 2012 Northeast Florida State Hospital

Patient Perspective

- Patients often have feelings of helplessness and frustration.
- They may react with aggression as an attempt to regain power.
- Restrictions and commands are often perceived as disrespectful and as threats to the individual's integrity.

Violence and threats: Comparing staff and patient experience
Omerov, Edman, & Wistedt, 2004

Patient's Perspective Experiencing Coercion

- The experience of coercion is not uncommon in the inpatient setting. The ability of staff to listen and respond to the patient's view reduces the experience of coercion. (Newton-Howes, 2010)

- A review of empirical literature related to coercion in psychiatric care found that it was not associated with improved functioning. It was associated with feeling dehumanized and unheard. (Newton-Howes & Mullen, 2011)

- A better working alliance was found with lower perceived coercion. (McNiel, Gormley & Binder, 2013)

- Individuals with betrayal trauma showed lower levels of willingness to trust. (Gobin and Freyd, 2009)

Responsible Authority

The inpatient psychiatric hospital setting has a power differential that can create a negative influence.

Situations can influence good people to do bad things. (Zimbardo, 2007)

A few suggestions for resisting negative influence

- Recognize it can happen to you.
- Be aware of principles of social influence (Cialdini).
  - Consistency - "We've always done it this way".
  - Social proof - "Others are doing it this way".
- Promote critical thinking and be mindful in interactions.
- Do not allow stereotyping or dehumanizing.
- Support conditions that help others feel self-worth.
- Be responsible and accountable.
- Examine rules and authority carefully, are they justified?

(Zimbardo and Wang, 2013)

Patients' reports of traumatic or harmful experiences within the psychiatric setting

- Being around frightening or violent patients (54%).
- Having medications used as a threat or punishment (20%).
- Hearing staff call other patients names (19%).
- Being called names by staff (14%).
- Witnessing aggression on the unit (57%).
- Most patients report feeling at least a little unsafe on their units.

They indicated improved staff-patient communication would be helpful.

(Frueh et al., 2005)

Examples of anxiety provoking situations
(Retraumatizing situations)

- Confinement
- Lack of privacy
- Embarrassing situations
- Lack of personal control
- Boredom
- Uncertainty about the future
- Being blamed or shamed
- Being made fun of
- Being rejected
- Being threatened
- Being coerced
- Being yelled at
- Forced medication
- Seclusion and restraint
- Witnessing violence/aggression
- Hidden agendas
- Being ignored
- Being denied needs
- Others….

Anxiety

- Serves to identify possible threats.
- Focuses attention on potentially threat related stimuli.
- Hypervigilant scanning may occur reducing attention.
- Focusing more upon threat related cues, may result in incomplete or inaccurate perception.
- Overall anxiety and arousal may trigger aggression.

Cognitive model of patient aggression, Winstanley, 2005

Cognitive model of patient aggression

A study of physical assaults and threats in a general hospital setting found;

- 83% of the incidents involved anxiety provoking situations.
- In 64% of the incidents patients showed thinking and reasoning impairment.

Consider the emotional state of the patient at the time of the incident.

- The individual is probably feeling anxious, vulnerable, and may not understand what is happening.

Anxiety provoking situations frequently occur in hospital settings.

The individual's baseline level of anxiety is likely to be high and this has a negative effect on thinking and reasoning.

(Winstanley, 2005, Winstanley & Whittington, 2004).

Increased anxiety can cause a misunderstanding of interactions
Situations may be considered hostile rather than safe

If patients do not recognize good intention of staff behavior;

- The behavior may be perceived as a threat.
- The normal reaction to a threat would be a fight or flight response.
- Flight is often inhibited in this setting leaving aggression as the only option.
- Aggression may be misdirected at the most available target.

Cognitive model of patient aggression, Winstanley, 2005

Increased anxiety can cause a misunderstanding of interactions
Situations may be considered hostile rather than safe

Aspects of the patient - staff relationship that may influence aggression

- Coercion (patient may not understand a request or slow processing may conflict with the need for staff to complete duties quickly).

- Power and Dominance (staff are in a more powerful role and patients are aware of this).

- Staff behavior (if observed in a different context, may be considered aggressive. Patients are expected to suspend the normal response of trying to defend oneself).

Cognitive model of patient aggression, Winstanley, 2005

Authority and Control

- Authority and control are tools that can be used in the therapeutic relationship.
- How, when, and with whom they are used are clinical and legal decisions.
- Control is often used in cases where there is a need to prevent the individual from harming self or others. It serves the purpose of containing the behavior more than influencing therapeutic change.
- Individuals with SMI or BPD may have a history of being subjected to abuses of power and authority. They may feel threatened to be in a situation that has a power differential similar to when they were a child.

Nobody enjoys being "bossed around" or "micromanaged" it is more effective to be a good coach or a good teacher.

Benson, 2013

Staff attitudes associated with increased violence include:

- Fear
- Expectation of violence
- Intolerance
- Authoritative interactions
- Minimal interaction
- Manipulative interactions

Nurses Limit Setting Styles
Lancee, Gallop, McCay, 1995

Aggression

- Assaults often occur while setting limits, administering medication or putting someone in restraints. (Lancee, Gallop, McCay 1995)
- Most common reason given for violence is conflict with staff - denial of privileges, denial of requests, enforcement of rules, denial of discharge.(Sheridan et al. 1990)
- Impulsivity by psychotic patients is driven more often by interpersonal interactions of limit setting or implementing rules rather than hallucinations or delusions. (Gallop et al. 1992)

Nurses Limit Setting Styles
Lancee, Gallop, McCay 1995

Aggression

- A review of studies evaluating aggression on inpatient units found that the staff's good communication skills, advocating, being available, accurately assessing, and collaborating with patients, decreased the potential for violence.
  (Harmon, Iennaco & Olsen, 2009)

- Inflexible and disengaged responding to individuals led to non-therapeutic outcomes. (Finfgeld-Connett, 2009)

- Higher rates of aggression were found on wards with nurses predominantly using restrictive and controlling interactions.
  (Duxbury, 2002)

- Wards with higher levels of conflict and containment were found to be using more temporary staff and more unqualified staff. (Bowers, Stewart, Papadopoulos & Iennaco, 2013)

Tough Love and the Trauma Survivor

- Lacks empirical support.
- Can re-traumatize because of past experiences with confrontation, criticism, punishment, rejection, and neglect.
- Not about breaking bad habits but teaching how to cope, to feel competence, self worth, and learning to trust others.
- Adolescent programs involving toughness strategies and scare tactics were found to be unsuccessful in reducing adolescent violence. (National Institutes of Health, 2004)
- Increased directiveness and confrontation by therapists predicted outcomes of more frequent and larger quantities of alcohol consumption for reactant clients in alcoholism treatment. (Karno & Longabaugh, 2005)

Aggression

- Individuals with PTSD were found to have significantly greater difficulty with anger and aggression. (Olatunji, Ciesielski & Tolin, 2010, Orth and Wieland, 2006, Jakupcak and Tull, 2005)

- Impulsive aggression has been found to be the most predominant form of aggression in PTSD. (Teten, Miller, Stanford, Petersen, Bailey, Collins, Dunn & Kent, 2010)

Causes of Aggression *(Love and Hunter)*

- Social Hazards
  - Inflexible rules
  - Crowding
  - Lack of resources
  - Mixture of severely disabled patients with Axis II patients
  - The need for power, establishing territory, personal safety (more noted with forensic individuals)

Patients' views of causes of aggression
Fagan-Pryor et al., (2003)

Six types of limit setting styles

based on over 4000 nurse responses

- Belittlement - responses causing person to defend their position.
- Platitudes - generic responses lacking attention to specific individual's situation.
- Solutions without options.
- Solutions with options.
- Affective involvement without options - expressing care, concern, attending to individual's subjective experience.
- Affective involvement with options.

Across diagnostic groups:

- Belittlement was more likely to generate anger.
- Affective involvement with options was least likely to generate anger.

Gallop (1989, 1990)

Nurses Limit Setting Styles
Lancee, Gallop, McCay 1995

Patients suggested the following interventions to reduce aggression:

- Improved medication management (4%)
- Improved handling of interpersonal conflict (64%)
- More flexibility in limit setting (32%)

(Ilkiw-Lavalle and Grenyer, 2003)

Knowledge about patients' perceptions makes empathic listening more likely. Training staff in empathic communication skills resulted in fewer assaults.

Patients' views of causes of aggression
Fagan-Pryor et al., (2003)

Inpatient psychiatric nursing skills related to creating a safe environment

Knowledge of the patient prior to the incident was helpful

- Nurses called it "getting a feel for the patient". If the patient was known to staff, they compared the current pattern of escalation to what they knew to be the patient's usual presentation. They developed a sense of a patient's presence on the unit, which helped them gain an understanding of the current status of the individual.
- Staff picked up more quickly on behaviors of patients that were known to them.

Awareness of the environment

- Nurses also demonstrated an awareness of when the environment was getting out of hand (when the noise, pace, and tone of interactions were building to a dangerous point).

Keeping the unit safe: Mapping psychiatric nursing skills Delaney and Johnson (2006)

Inpatient psychiatric nursing skills related to creating a safe environment

Caring and connecting

- The ability to be fully present in a situation and learning to respect the client as an individual.
- In one response, a patient reported a belief that the staff thought she was important because they asked her how she was doing on several occasions during a stressful time.

Remaining calm

- Several nurses reported a calm or muted response to a situation was a more efficient way to control an environment contagion.

Keeping the unit safe Delaney and Johnson (2006)

Inpatient psychiatric nursing skills related to creating a safe environment

Empowering

- Nurses noted the value of treating patients as adults who must re-achieve self-determination.
- It was important for the staff to show:
  - A willingness to help, not needing to correct.
  - A balance between tolerance and control.

Effective interventions embraced an attitude of respect for the individual and a confirmation of their autonomy.

Keeping the unit safe Delaney and Johnson (2006)

- Nurses with higher levels of training were found to show a significantly greater preference for respectful and autonomy-confirming interventions than more junior nurses.

Lowe, Wellman & Taylor, 2003

Ideology

- Provide a safe environment so that patients can work on treatment issues.
- Staff need to understand the meaning of patients' behavior and adjust their responses to the behavior as their understanding of causes evolves.
- Respect for the patient is a critical value. Interactions should be non-confrontational, never harsh, and should respect the individual's dignity.

Keeping the Unit Safe
Johnson &Delaney, 2006

Individuals with a history of traumatic experience

- Have a heightened sensitivity to environmental stressors.
- Have an impaired ability to self regulate emotional responses to stressors.

A safe place is needed to begin healing

Sensory Comfort Rooms:

One example of a therapeutic environmental tool that promotes the development of self regulatory coping skills.

Comfort Rooms

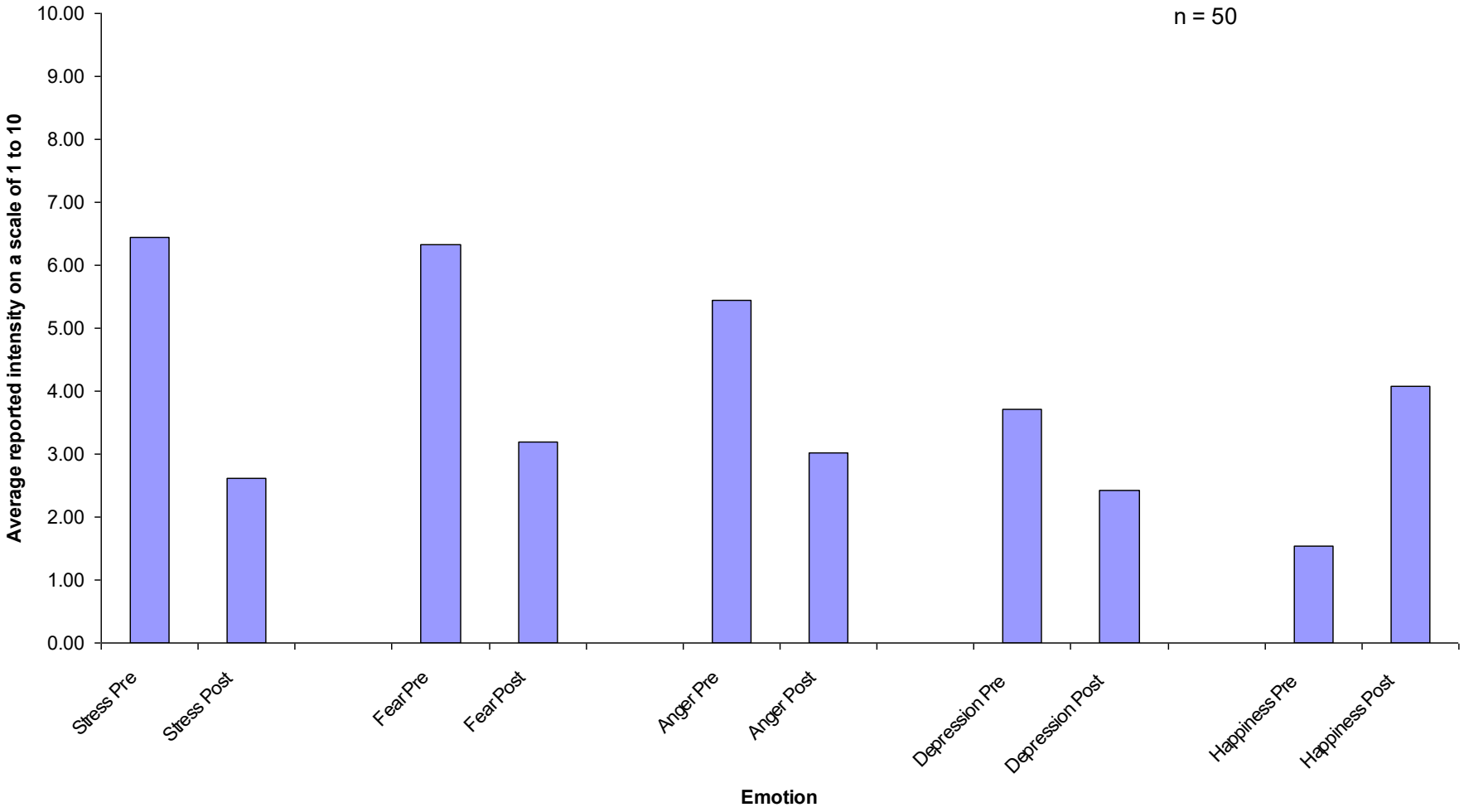
A therapeutic environmental tool that promotes the use of self-regulatory coping skills by providing calming, relaxing stimuli as a distraction from adverse environmental stressors and internal distress.

Northeast Florida State Hospital

A sensory comfort room:

- Is **not** an alternative to restraints. **It is a prevention tool** to avoid episodes of restraint or seclusion by promoting emotional self-regulation.
- Is **not** a seclusion or time-out room. An individual is never forced to go.
- Is **not** a reward for good behavior or a privilege that can be taken away as punishment.
- Is **not** to be used after an individual has already lost control of his/her behavior.

Self Reported Emotional Intensity Before and After Using the Comfort Room



Benson, 2012 Northeast Florida State Hospital

Beginning at admission

Document

- preferred interventions
- triggers of aggression
- early signs of agitation

Make this information easily accessible and update it regularly.

Guide for managing acute aggressive behavior
dosReis, Barnett, Love, & Riddle, 2003

Following an aggressive or self injury incident

- Reassess precipitating factors.
- Evaluate effectiveness of interventions.
- Establish trends.
- Recommend interventions.
- Develop preventive strategies.

Guide for managing acute aggressive behavior
dosReis, Barnett, Love, & Riddle, 2003

Escalation Avoidance Summary & Evaluation

(EASE)

Name: _____ **Date:** _____ **Time:** _____

Awareness

Observed a change in:

☐Emotion ☐Verbal Interaction ☐Physical Energy ☐Social Interaction ☐Other

_____

_____

Understanding

Change may have been caused by:

☐Not feeling safe ☐Not feeling understood ☐Not feeling in control ☐Feeling no one cares

☐Loss or disappointment ☐Failure ☐Guilt or shame ☐Feeling alone ☐Feeling trapped

☐Other_____

Dialogue

☐**Gently acknowledged you noticed a change** "Mr./Ms.____, you seem a little distressed/worried/nervous/upset", be careful not to make the person feel defensive
☐**Respectfully asked how the individual is feeling** "What are you feeling right now?" Listen and accept feelings as real experiences for that individual at that moment. Feeling understood and acknowledged is important.
☐**Offered assistance** "Would you like to talk with me for a few minutes?"

Identify

☐**Genuinely acknowledged the individuals feelings and concerns without minimizing or criticism.** Help the individual feel that you are listening and truly understand their feelings.

Options

☐**Offered a few possible solutions and choices.** Help the individual recognize you as someone they can trust and as someone who wants to help.
☐**Provided support and encouragement to build hope and confidence.** Help them to feel that things can get better.

Staff Name(s):_____
Comments:_____

Henry Benson, Ph.D.

Northeast Florida State Hospital, 2011

Escalation Avoidance Summary & Evaluation (EASE)

Awareness

Observed a change in:

Emotion Verbal Interaction Physical Energy
Social Interaction Other

Understanding

Change may have been caused by:

Not feeling safe Not feeling understood Not feeling in control Feeling no one cares Loss or disappointment Failure Guilt or shame Feeling alone Feeling trapped Other

Escalation Avoidance Summary & Evaluation

Dialogue

Gently acknowledged you noticed a change "Mr./Ms.____, you seem a little distressed/worried/nervous/upset", be careful not to make the person feel defensive.

Respectfully asked how the individual is feeling "What are you feeling right now?" Listen and accept feelings as real experiences for that individual at that moment. Feeling understood and acknowledged is important.

Offered assistance "Would you like to talk with me for a few minutes?"

Escalation Avoidance Summary & Evaluation

Identify

Genuinely acknowledged the individual's feelings and concerns without minimizing or criticism. Help the individual feel that you are listening and truly understand their feelings.

Options

Offered a few possible solutions and choices. Help the individual recognize you as someone they can trust and as someone who wants to help.

Provided support and encouragement to build hope and confidence. Help them to feel that things can get better.

A starting point for additional inquiry

The Story of A Child's Path to Mental Illness and Suicide.

The "ACE" Study & Unaddressed Childhood Trauma

Ann Jennings Ph.D.

www.TheAnnaInstitute.Org