



The Mandt System®

Putting People First

Conceptual

Section 2

Conceptual Skills

Chapter 4: Trauma Informed Services

Chapter 5: Positive Behavior Support

Chapter 6: Liability and Legal Issues

Chapter 7: Medical Risk Factors

Section Introduction – Conceptual

As stated earlier, building healthy relationships is the ultimate goal of The Mandt System®. We want to look at all relationships present in the workplace, and not just focus on relationships with the customers, clients, students or whatever other name is used to describe the group of people receiving or purchasing goods and services from your organization. Once healthy relationships have been established, there are three core competencies we want to give you so you can not only build healthy relationships but also use skills to address conflicts and meet unresolved needs.

The **Conceptual** chapters now focus on using skills and competencies. We will carry with us the three models of **Maslow’s Hierarchy of Needs**, **Proactive Interaction** and the **Crisis Cycle** and add several additional models that will serve as tools that will empower people as they focus on **Trauma Informed Services**, **Positive Behavior Supports**, **Liability and Legal Issues** and **Medical Risks of Restraint**.

Chapter Four, **Trauma Informed Services**, was written to help you work better with people who have experienced significant, and in many cases, ongoing trauma. These are people who may have experienced some type of traumatic event that was a “one time” occurrence, such as a natural disaster. Or they may have been victimized by other people: terms like abuse, exploitation, dehumanization, degradation can best describe what has happened to these people.

At a **conceptual** level, we want to give you the background information that may be helpful to you in the role you have with this person. ***If you are not already a therapist, this information will not make you a therapist.*** The information being given here will not make you a clinician, but it may help you to become more aware of the effects of trauma on the people you serve, and provide a safer environment in which they can live, learn, work, and play with an increased feeling of safety. It may also give you the ability to support people and to respond to them in ways that do not retraumatize them.

Remember that injury does not have to be physical. As children, many of us said, “Sticks and stones will break my bones but words will never hurt me.” Truth be told, most of us were wounded far worse by words than any stick or stone that could be hurled. In the first section, you were introduced to the concepts of Interactions, Incidents, and Crises. The intention of The Mandt System® is to give you the tools needed to keep interactions at the interaction level. ***These next three chapters are aimed at what to do when an interaction may become an incident.***

Chapter Five, **Positive Behavior Support**, was written to help people implement behavior support plans, not to write them. The more people know about positive behavior support and the reasons behind how a plan is written, the easier it will be to help the people writing those plans by giving them the information they need, and the easier it will be to implement the plans once they are written.

Chapter Six, **Liability and Legal Issues**, provides an introduction to the legal issues surrounding the provision of services to people in educational, developmental disabilities, mental health and substance abuse, and other human services settings. Since none of us are attorneys, we cannot give legal advice, but we can give legal education by sharing the knowledge we have gained through the use of our skills and competencies as administrators, educators, social workers, expert witnesses, and direct support professionals.

Chapter Seven, **Medical Risks of Restraint**, was written to provide an overview of the risks of physical restraint, using literature written by medical professionals. None of the authors of this chapter are licensed medical professionals. If you have any concerns about the health and welfare of people, whether people who receive services or people who give services, seek the advice of a licensed medical professional.

David Mandt and Associates has collected literature and experience over the past 30 years in the development of the physical techniques used in the training. We are especially concerned with the prevention of restraint related deaths. Restraint related death can be prevented. **We require that everyone who uses the technical (physical) skills in the Mandt System must complete this Chapter prior to being trained in any of the Technical Chapters.** We also strongly recommend that everyone who is trained in the physical techniques of the Mandt System also have First Aid and CPR training.

Conceptual



The Mandt System®

Putting People First

Chapter 4

Conceptual Skills

Trauma Informed Services

Recommended teaching time is 2 – 3 hours

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Introduction

Trauma can affect anyone. Almost all people have experienced the loss of a loved one, and the intense grief that often accompanies death. Many people have had the experience of being in a tornado, hurricane, flood, or earthquake. We have all experienced loss throughout our lives to one degree or another; it is part of being human.

You, the reader, are taking a class in The Mandt System®. You are working with and for people who need something you can offer as a teacher, social worker, direct support professional, therapist, mental health technician, or any of the literally thousands of titles describing the work people do as a service and support for other people.

Our Purpose

This chapter is to help you work better with people who have experienced significant and in many cases, ongoing trauma. These are people who may have experienced some type of traumatic event that was a “one time” occurrence, such as a natural disaster. Or they may have been victimized by other people: terms like abuse, exploitation, dehumanization, degradation can best describe what has happened to these people.

This information is being shared with you at a **conceptual** level. We want to give you the background information that may be helpful to you in the role you have with this person. ***If you are not already a therapist, this information will not make you a therapist.*** The information being given here will not make you a clinician, but it may help you to become more aware of the effects of trauma on the people you serve, and provide a safer environment in which they can live, learn, work, and play with an increased feeling of safety. It may also give you the ability to support people and to respond to them in ways that do not retraumatize them.

Acknowledgements

Many people offered suggestions in the development of this chapter, and we want to acknowledge the contributions of the members of the Advisory Committee to David Mandt and Associates, who contributed a number of helpful comments as they reviewed this chapter. We also want to thank June Phelps, Ph.D., a child psychologist in Canton, Ohio, who reviewed the material and provided training to the members of the Training Faculty in the area of trauma.

After the devastation of Hurricane Katrina, we were privileged to provide this training to the therapists and case managers of mental health centers in Tupelo, Hattiesburg, and Gulfport, Mississippi. Their comments and suggestions were incorporated into the material and has made this chapter more relevant to people who have may have had similar experiences.

Learning Objectives

By the end of this chapter, students will have:

1. Identified the effects of trauma on people.
2. Differentiated between the two types of trauma.
3. Recognized that different traumatic events will affect different areas of an individual and the type of supportive response needed.
4. Identified the internal and external factors that influence resilience to trauma.
5. Developed an understanding of the ways in which trauma early in life affects development.
6. Chosen supportive interventions which support the whole person, not just focusing on his/her specific behaviors in response to the trauma.
7. Understood the importance of trauma informed services in preventing possible retraumatization.

8. Developed an awareness of retraumatization as a negative consequence of using restraint and strategies to minimize it.

Preparation for Discussion

Think of some events that caused situational trauma for people. What words come to mind?

These words demonstrate the power of trauma. Almost everyone over the age of 18 can tell you where they were and what they were doing on 9/11. For this generation, 9/11 had a similar impact to the assassination of President Kennedy to one generation, and Pearl Harbor to another. Think about the feelings you had when these events occurred, and imagine the feelings of people who have experienced and/or continue to experience trauma on an ongoing basis. The December, 2004 tsunami likewise had a powerful impact around the world, as did the recent hurricane Katrina.

As you learned in the first chapter, *Building Healthy Relationships*, stress can cause people to change their behaviors and enter the Crisis Cycle. There are many different types of stress and not all of the stressful events people experience result in a sense of trauma for them. In the same way, what may be a low level stress for you may be perceived much differently by others.

NOTES:

Two Models to Understand Traumatic Stress

There are two types of trauma we want to address. The first is the result of “**acute episodic trauma**” which is defined as a life-threatening event that occurs to individuals or to an important other, over which they have no control, and is often, though not always, the result of natural disasters. The stress people feel as a result of this type of event can last up to one month without meeting the criteria for post-traumatic stress disorder (PTSD) (Phelps, 2005).

The second type of trauma is usually the result of “**interpersonal violence**.” It is more narrowly defined by The National Association of State Mental Health Program Directors (NASMHPD) has:

“the personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss, and the witnessing of violence.”
(NASMHPD, 2005)

What we are going to focus on in this chapter is how to work with people who have experienced acute episodic stress, and people who have experienced trauma resulting from interpersonal violence. **Trauma Informed Services** is a more accurate description of the material presented in this chapter. As Roger Fallott has said, “Trauma-Informed Services - incorporates knowledge about trauma, prevalence, impact, and recovery in all aspects of service delivery. [It] Minimizes revictimization and leads to services that are **hospitable** and **engaging** to survivors.” (Fallott, 2005) We will, in our training, review ways to support and facilitate effective recovery for trauma survivors based upon evidence of the effectiveness of the practices presented in this chapter.

This information is being presented as a way to train non-licensed staff, who often are in more frequent contact with trauma survivors than licensed staff, to offer supports and services that:

1. Meet immediate needs for basic human needs and safety
2. Are sensitive to provide services and supports respectfully so as to not re-traumatize the person
3. Perceive responses to trauma as “normal responses to abnormal situations,” to quote a commonly used phrase
4. Incorporate the experiences of individuals served into our interactions with them, whether those interactions are more informal or are directed by some type of specifically designed individual plan

The two words in bold from Follot’s definition of Trauma Informed Services are important to understand. Whatever the source of the trauma, we want to provide services and supports to survivors in settings that are **hospitable**, which means an environment that is safe and where healing can take place. The environments are also **engaging**, which means that the people will do more than receive services they will participate and in fact lead the process of their own recovery. In chapter 1 of The Mandt System® we used the word “co-management” to describe our approach – we work with and we work for people who may have experienced some form of trauma; in doing so, we engage in the process of recovery together.

Responding to Acute Episodic Stress

The following material is adapted from The American Academy of Experts in Traumatic Stress (AAETS). (Lerner and Shelton, 2005) When people experience significant levels of stress and/or trauma, their responses can fall into one of the areas below. It is important to remember that we as staff may also have similar responses.

Areas of Assessment

Area	Individual Served	Staff Supportive Response
Physiological	People can be injured by the traumatic event, such as an accident, severe weather, abuse, or other significant event.	Ensuring immediate physical safety is critical. Use the skills taught in First Aid, CPR, call 911, etc.
Emotional	Feelings such as hopelessness, helplessness, panic, severe anxiety, irritability, or “emotional numbness” can occur. Different people will probably react differently; people normally very active can become depressed and withdrawn while people normally very calm and cool can become “hyper”.	Remaining calm is one of the best things you can do. You will need to affirm your feelings and then choose your behaviors. As the staff person, you will need to make sure to manage your own behavior; this provides a calm, safe setting and teaches others how to handle stress in the future (Chapter 1).
Psychological	Some of the people you serve may be affected by mental health needs such as schizophrenia, borderline personality disorder, etc. Severe stress or trauma may exacerbate pre-existing conditions.	Follow the guidelines and treatment plans provided by the clinically qualified staff. If you are working with someone who does not have a therapist/counselor, you may need to refer the individual for services.
Cognitive	Under stress, people may have shorter attention spans, increased activity levels, and short term memory impairment. Neurologists say we can hold between 3-7 things in short term memory; under stress those numbers decrease.	One of the best things we can do as staff is to lower task expectations, and take away as much stress as possible. Accept the fact that people will be able to accomplish less when they have more stress. Give memory aids such as breaking tasks down into smaller steps
Spiritual	After 9/11 there was a significant increase in attendance at places of worship of all faiths. Some people may turn to their faith while others may turn away as a result of the stress and/or trauma.	Be sure to support the person and not impose your own approach to the question of spirituality. Do not try to convince them that their answers are wrong, and if they question why this happened, the most honest answer is “I don’t know.”

Responding to Acute Episodic Trauma

The majority of the people your agency or organization serves, and almost all of the staff, will one day experience or already have experienced Acute Episodic Trauma. This is the kind of stress that comes from common human experiences. *"Although most people have a strong, initial reaction after an acute episodic trauma (e.g., high levels of fear) most people do not develop a psychological disorder such as posttraumatic stress disorder or major depression. Factors that influence whether a person will develop a psychological disorder after an acute trauma include: prior history of trauma, the nature of the traumatic experience (e.g., did anyone get physically injured), and the nature of the recovery environment (e.g., degree of social support).* (Phelps, 2005)

The American Academy of Experts in Traumatic Stress (AAETS) (<http://www.aaets.org>) uses a three-pronged strategy to respond to stress: **Prepare, Stabilize, and Recover**. This is an excellent strategy to address those traumatic events that can occur within your organizations, such as:

- Serious injury or death of individuals served and/or staff
- Serious abuse and/or neglect
- Automobile accidents
- Traumatic events in the area in which you live (tornado, flood, hurricane, etc.)
- Death or serious illness of a parent or other close relative of individuals served
- Criminal acts of a random nature (drive-by shootings) and other forms of terrorism

The approach used by AAETS is called **Comprehensive Acute Traumatic Stress Management**. Resources from AAETS are included on the CD-ROM you received as part of this training. Episodic trauma can have serious effects on people, although most people are resilient and do not develop Post Traumatic Stress Disorder (PTSD). However, this kind of stress must be addressed, and following is a synopsis of the ten steps recommended by AAETS to address Episodic Trauma.

Preparing:

Acute episodic trauma is faced by a majority of human beings at some point in their lives. In human services, this is even more true, given the types of services offered, the experiences of the individuals using those services, and the environments in which many of us work.

Preparing for the eventually of acute episodic trauma is, we believe, the responsibility of every organization. On the CD-ROM accompanying this manual, there is more detailed information on this topic. **Preparing for acute episodic trauma is a management responsibility**, and as such will not be covered in depth in this chapter.

Stabilizing:

Part of the work that we do as human service professionals is to walk through the experience of acute episodic stress with the person. We learned in Chapter 1 (Building Healthy Relationships) that when the people we serve experience stress, we will be experiencing similar stresses. Our responsibility, then, is to manage our own behavior and to practice the principle of “Respond, Don’t React” to the stresses we encounter.

As stated in Chapter 1, when we respond, we affirm our emotions and choose our behaviors. We also provide a safe haven for those around us, by the simple fact that we are acting in as calm a manner as possible. We are also teaching others how to respond to future stress by the way we respond to the present stress.

Stabilizing a situation and the people involved and affected by the acute episodic trauma requires that we first deescalate ourselves. We are going to have emotional responses to the stresses at hand; we are human and will have a range of emotional responses. To help other people, though, we need to deescalate ourselves so that we can provide the stability others need and expect from us in our roles within the organizations within which we work.

When people are experiencing acute episodic trauma, we need to “be there” for them. What this means is that we will walk side by side with them, holding their hands figuratively, if not also literally. Many people, when they reflect back on their own stresses, say that the most helpful intervention was having a friend who was simply there, and who in some cases said very little. By their physical presence, they provided stability, safety, and the promise that they would be there for them in the future.

As we stabilize a situation, we need to use the tools provided in Chapter 1 – focus on their basic human needs first (Maslow), keep your RADAR on to be aware of any unmet needs, and know where they and you are in the Crisis Cycle.

Remember that RADAR stands for:

Recognition - recognizing that something is going on, using all your senses.

Assessment - assessing what is happening to everyone, starting with yourself. Assess the environment as well.

Decision- deciding what to do after you have recognized and assessed.

Action - actions take the form of a verbal response (not a reaction), a generalized physical response, or a specific physical response.

Review Results – results are now evaluated. Did you achieve the goals of your action(s)? If not, what is your next step?

When you are working with people, you want to keep your RADAR on! The earlier you can intervene, the better chance you have of preventing interactions from becoming incidents, or incidents from becoming crises!

We want to use the RADAR model, Maslow’s Hierarchy of Needs and the Crisis Cycle model as we review the 10 steps in the **Comprehensive Acute Traumatic Stress Management (CATSM)** model developed by AAETS. It is important to remember that this is a model to guide staff interaction, and often may not flow in a linear fashion. The steps in the model are identified in **bold**:

1. Ensure the **physical safety** of all people, including yourself. If you are not safe, consider whether or not it is appropriate for you to begin intervening.
2. Assess the **mechanisms of injury**. CPR and First Aid training provide excellent structures for assessing physical injuries. Pre-existing health conditions are risk factors in times of acute episodic trauma. Remember to **assess psychological and emotional injuries as well**. If there is any concern about psychological and emotional injury to the individual, refer them to a licensed mental health practitioner!

3. **Evaluate** the level of **responsiveness of the individual(s)**, keeping in mind the baseline behavior (chapter 1) of the individual. Some people are active in the Stimulation Phase, while others are quiet and subdued in the Stimulation Phase.
4. **Address medical needs** immediately before moving on.

Recovery:

The next 5 steps in the AAETS model of CATSM fall in the recovery phase of the model.

Our purpose in helping people to recover from the effects of the acute episodic stress is to support them to return to their baseline behaviors or “personal best.” This will mean listening to the facts and the feelings that people share with you. To do this you will need to use the tools of

...

- A. Active Listening (chapter 2)
- B. Reflective Listening (chapter 2)
- C. Perception checking (chapter 3)
- D. Building empathy (chapter 3)

... as you help the person to recover from the event.

1. **Observe and identify** who may have been affected by the traumatic event. Remember that people who were not directly involved may still be affected by the traumatic event.
2. **Connect with the individual** by using their name (chapter 2) and introducing yourself, if you are not known to them. Be sure to respect their need for space or closeness (Proxemics, chapter 2), and assess how close or far away you need to be to maintain your safety.
3. **Ground the individual** by listening to the facts and the feelings they are sharing in both their verbal and non-verbal communications (chapters 2 and 3). Remember to make sure you know the facts surrounding the incident, and do not argue with them or tell them that their perception of what happened is wrong. This is their stress, not yours! Use active listening skills to really hone in on the facts, and reflective listening skills to hone in on the feelings, and to be authentic (chapter 3) in your communication. It is important to reestablish routines as quickly as possible, remembering that safety is the result of consistency and predictability.
4. **Provide support** to the individual, building on the empathy developed in step 7. One mistake people sometimes make is to tell people they know exactly how they feel (chapter 3), while another is to tell people what they should or should not feel (chapter 1). Remember, you are supporting the individual who has experienced acute episodic stress. It is their stress, not yours! If they feel something you do not, your job is not to figure out why, but rather to support them as people.
5. Now you are ready to help them by **normalizing the response**. Many people, when they have gone through an acute episodic trauma feel that their responses were somehow “wrong” or that they were “different” from others. We emphasized in chapter 2 that emotions are not right or wrong, they are simply ours, and we need to empower people to feel their feelings, affirming that their responses were simply that – their responses. There may be a need to limit behavior for safety reasons. If people are acting on their emotions in ways that cause harm to others or themselves, then behavioral limits would need to be in place, using the skills taught in chapters 1, 2, and 3 to de-escalate their behavior. **Caution: If people are sharing information that indicates a high level of stress, thoughts of being hurt or hurting themselves, refer the individual to a licensed clinician.**

After the individual has been stabilized using the previous five steps, we next help the person to:

- 6. Prepare for the future** – remember that unless you were a therapist when you came to this training, you will not be a therapist when you leave! This is not therapy; this is helping them develop a road map for what comes next for the individual, referring them to someone else for more specific services, dealing with the day to day choices that we all face after experiencing an acute episodic stress. People will need to move on from here. Your interactions with them may be very brief, or part of a long-term supportive relationship. Whatever your relationship is, we need to move on and help the person to move on from here.

Learning from the Past:

When people have experienced acute episodic trauma, part of preparing for the future is learning from the past. If there are things to be done differently, i.e. get a weather radio, respond quickly to evacuation suggestions, etc, then we want to help people to learn from the past. One helpful way to structure this is to use the approach known as “processing” (taught in Chapter 2), which is to say the decisions you made in the past were the best ones you could make at the time, given the information you had. The question is not “what did you do wrong,” but rather “what worked, and what will we do differently in the future.”

NOTES:

Supporting Staff

There are many instances in which natural and man-made disasters affect entire cities, counties, states, provinces or even countries. In such cases, staff must make sure they take care of themselves as they prepare to take care of others. One of the statements we repeat often in The Mandt System® is **“affirm your emotions, choose your behaviors.”** To offer stability, staff must stabilize themselves. Practicing teamwork, supporting each other, and accepting support are all critical elements in supporting staff.

When responding to the stress of others, we may have emotions that are triggered in us. It is normal to experience this! We need to affirm these emotions, and then choose the behaviors that are most helpful to the people whom we are supporting. If there are situations where this is difficult, it is important to be honest about this, and to know our own limitations. We may do more harm than good if we are unable to affirm our emotions and choose our behaviors.

The National Center for Child Traumatic Stress has prepared a helpful monograph on this topic, which is included in the references section in the accompanying CD-ROM.

Triaging Trauma – When Should Professional Help Be Sought?

Some of the people with whom you are working may be affected to a greater degree by the traumatic event, and need more support than most of us can offer. We again want to emphasize that this training will not make you a therapist or counselor. We do want to give you some things to look for in the behavior of people that may help you decide whether or not to refer this person to a clinically licensed professional such as a psychologist, social worker, counselor, psychiatric nurse, psychiatrist, or other licensed professional.

If there is any doubt in your mind as to whether or not a person may need to be assessed by a clinically licensed professional, we recommend you make the referral and allow this person to complete the assessment and provide the services and supports the person may need.

The following information comes from the American Psychological Association, and provides an excellent framework for making decisions about when to seek professional help from licensed mental health practitioners:

“Some people are able to cope effectively with the emotional and physical demands brought about by a natural disaster or other traumatic experience by using their own support systems. It is not unusual, however, to find that serious problems persist and continue to interfere with daily living. For example, some may feel overwhelming nervousness or lingering sadness that adversely affects job performance and interpersonal relationships.

Individuals with prolonged reactions that disrupt their daily functioning should consult with a trained and experienced mental health professional. Psychologists and other appropriate mental health providers help educate people about normal responses to extreme stress. These professionals work with individuals affected by trauma to help them find constructive ways of dealing with the emotional impact.

With children, continual and aggressive emotional outbursts, serious problems at school, preoccupation with the traumatic event, continued and extreme withdrawal, and other signs of intense anxiety or emotional difficulties all point to the need for professional assistance. A qualified mental health professional can help such children and their parents understand and deal with thoughts, feelings and behaviors that result from trauma.”

(Retrieved from <http://www.apa.org/practice/traumaticstress.html> September 14, 2005)

We hope this short section on acute episodic trauma will provide staff within human services organizations the resources they need to better support individuals in times of acute episodic trauma. We are now ready to move to the next topic in this chapter.

The Effects of Trauma – Interpersonal Violence:

In the previous section, we presented a model for working with people who experienced significant stress, when that stress was episodic, a one-time event. Remember that the definition of trauma is:

“the personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss, and the witnessing of violence.”

Again, we want to reiterate that not all people who are exposed to Adverse Childhood Experiences (ACE) develop behaviors that put themselves and/or others at risk. However, many of the people that are served in mental health, developmental disability, education and correctional programs have histories of exposure to ACE's. Restraint in and of itself is an adverse event.

The Centers for Disease Control (CDC) and Kaiser-Permanente Insurance in California (2003) studied over 18,000 adults who were followed for a period of 10 years, to look at the effects of Adverse Childhood Experiences (ACE) on adult behavior. Adverse Childhood Experiences were defined as **growing up (prior to age 18) in a household with:**

Adverse Childhood Experiences:

Recurrent physical abuse.	Someone who is chronically depressed, suicidal, institutionalized or mentally ill.
Recurrent emotional abuse.	Mother being treated violently.
Sexual abuse.	One or no biological parents.
An alcohol or drug abuser.	Emotional or physical neglect.
An incarcerated household member.	

Note: The study looked at what happens when people experience four (4) or more of the above events.

The researchers then looked at the incidence of I.V. drug abuse, alcohol abuse, and suicide attempts. People who experienced **four or more of the above ACE's** had:

6 times the rate of I.V. drug use than those that had no ACE's

7 times the rate of alcohol abuse than those that had no ACE's

9 times the rate of attempted suicide than those that had no ACE's

(Note: the above information was retrieved from <http://www.cestudy.org/docs/GoldintoLead.pdf> on May 25, 2005)

In this chapter, we are going to be exploring ways to help you provide services and supports, based on evidence of effective practices, to the people with and for whom you work. In that sense, then, most of the people who will be using The Mandt System® will be providing non-clinical services in educational, residential, vocational, recreational, and correctional settings. Some of the people taking this course will be clinicians, and the information presented here may be dealt with in more depth in training received at a clinical level.

Many of the people whom you serve may have experienced recurrent abuse, neglect, and other forms of violence when they were children. Some of them have continued to experience trauma as adults, while others experienced abuse and neglect as adults. Research indicates that the prevalence of trauma is widespread in Europe and North America, with over 25% of females in a study of naval recruits reporting that they were victims of trauma (Cunradi et al, 2005). Between 3.3 million and 10 million children are estimated to suffer abuse in the US annually (Family Violence Prevention Fund, 2007).

“Study findings indicate that adults in psychiatric hospitals have experienced high rates of physical and/or sexual abuse, ranging from 43% to 81%. Other research recently has found that 92% of homeless women and 81% of non-homeless women in poverty had been physically and/or sexually abused.” (Position Statement on Services and Supports to Trauma Survivors, retrieved from <http://www.sidran.org/nasmhpd.html> August 25, 2005). People affected by developmental disabilities have also experienced significantly higher rates of trauma. Over 85% of children in Residential Treatment Centers have trauma histories. (CWLA, 2004)

“Universal Precautions” in the medical field means that contact between people involving bodily fluids result in harm or injury through transmission of germs. In this chapter, Universal Precautions means we will assume that every person we work with has a trauma history. In this way, we can best minimize the retraumatization that sometimes results when services and supports are provided to people.

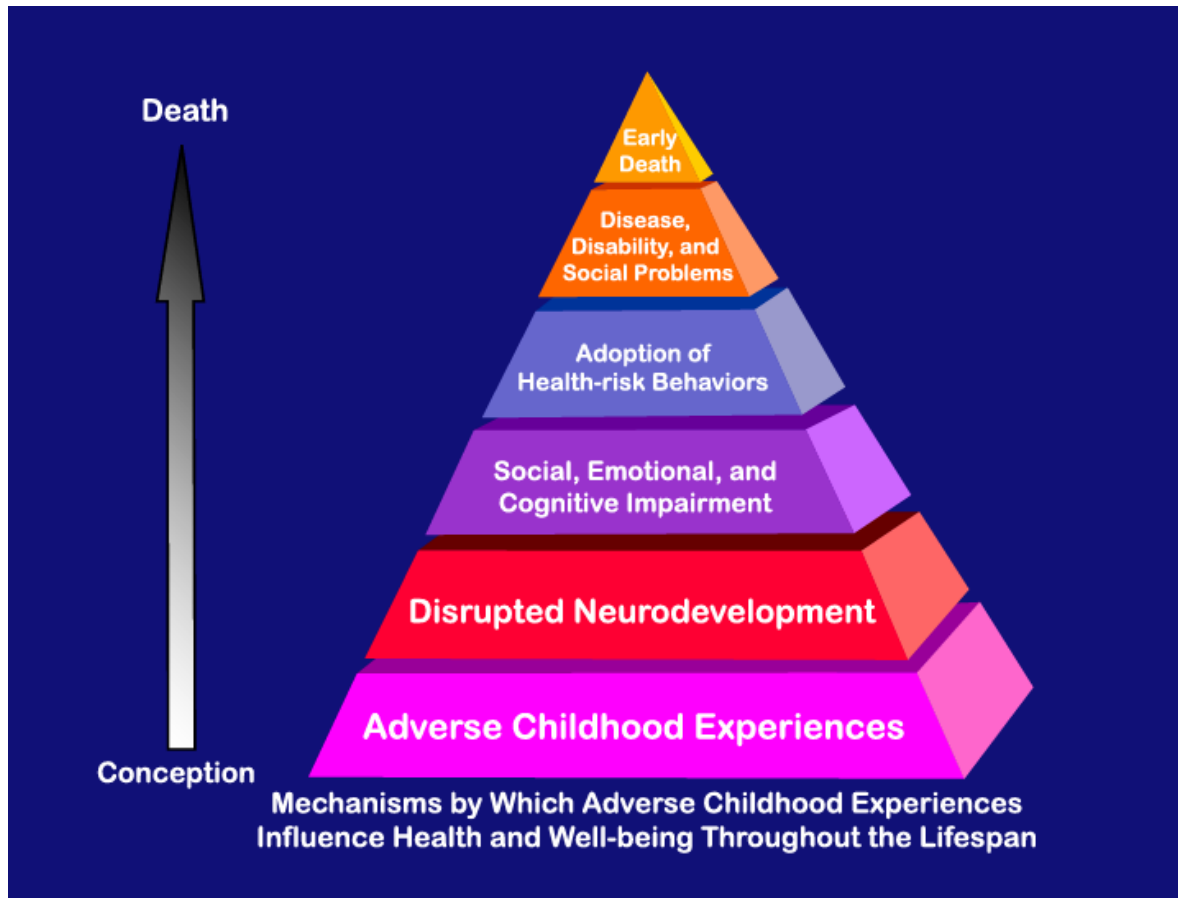
We can not go back and undo the past. But we can use what we know about the past histories of each of the people we serve to inform how we interact with them today and how we will interact with them in the future. We can use what we know to create individual plans for them, whether those plans are implemented in mental health, developmental disabilities, correctional, educational, or other settings.

This approach is known as Trauma Informed Services, which takes into account the trauma histories of individuals and incorporates that history into their plan, whether it is known as a treatment plan, recovery plan, habilitation plan, behavior support plan, rehabilitation plan, individual education plan, etc. If trauma histories are not taken into account, then whatever interventions are used to support the person may in fact re-traumatize the person.

While the ideas inherent in Trauma Informed Services grew out of services to people affected by mental illness, the model is applicable in all settings. Schools, group homes for people affected by developmental disabilities, special education programs, correctional programs, etc., all serve individuals who may have experienced significant trauma in their lives. In fact, with the exception of “regular educational services”, most of the people served in your organizations will have been subject to trauma at a significantly higher rate than the general population.

In Chapter 1, we focused on Building Healthy Relationships, and shared quotes from Dr. Peter Breggin and David Pitonyak on the importance of healthy relationships in supporting people, not just their behaviors. When working with and for people who have experienced significant trauma, relationships that engender trust and provide safety are even more important.

The ACE Pyramid



Source: <http://www.nsvrc.org/about/cdc.html>, retrieved May 25, 2005

One Person's Experience:

Amanda is a woman who experienced severe and repetitive abuse as a child, and developed what for her were adaptive behaviors which served to keep her safe but also resulted in harm to others. When people experience significant trauma early in life, the above diagram shows how they adapt to and are affected by the trauma:

Note the line on the left hand side shows the time period from conception to death. The earlier the abuse occurs in the life of the child, the more **disrupted neurodevelopment** may be. A number of different studies have documented the neurological effects of stress on neurological development (Bremner, 1999, DeBellis, 1999). One of Amanda's diagnoses was Partial Complex Seizure Disorder, which is found in about 30% of cases to be associated with a history of severe abuse (Gates, 2003). Other forms of disrupted neurodevelopment may include an increased level of neuro-hormones that prepare the body for fight or flight (or freeze), fragmented memories. Individuals affected by PTSD have been shown to have a smaller hippocampus (memory) than people not affected by PTSD. (Benner, 1997) (Phelps, 2005)

The next step in the pyramid is the **Social, Emotional, and Cognitive impairments** which occur, as the child begins to interact with their environments and the people within them. Partly as a result of the disrupted neurodevelopment and partly as a result of the complex interplay between individuals and the environments in which they live, learn, work and play together, people develop social, emotional, and cognitive interaction skills which they use. In the chapter on Behavior Support, behavior is defined as the way in which we get our needs met, respond to the demands placed on us, influence our environments, and communicate with others.

One of the effects of trauma, then, is the development of behaviors which accomplish these things in ways that keep us safe. When we feel unsafe, we will do everything we can to either manipulate the people around us, or keep them at a safe distance physically, emotionally, or both. Amanda developed a set of behaviors which she said were chosen to keep people away from her. At the same time, though, she craved social relationships, and so at times she would want to get close, while at others she pushed people away. This is one of the hallmarks of Borderline Personality Disorder, another of Amanda's diagnoses. Amanda also has a diagnosis of Borderline Intellectual functioning, which many believe is attributed to her history of abuse.

The next stage in this model is the **Adoption of Health-Risk Behaviors**, which can be seen as attempts on the part of the individual to cope with the effects of the trauma they feel by escaping the pain through drug and alcohol use, engaging in abusive behavior themselves, and by attempting suicide. Again, Amanda had a history of substance abuse, suicidal thoughts, and homicidal thoughts.

As a result of the adoption of health risk behaviors, people who experience four or more ACE's are more likely to experience **disease, disability, and social problems**, finally culminating in **death**.

Amanda developed a series of behavioral responses to the trauma she experienced which kept people away from her. If they were far away both physically and emotionally, then she would be less likely to be hurt in the future as she had been in the past. The clinical term used to diagnose and describe her way of coping with this stress is Borderline Personality Disorder.

Many studies have found a high correlation between the diagnosis of Borderline Personality Disorder and traumatic abuse in women. (American Journal of Psychiatry, 1990; Goldman, et. al.; American Journal of Psychiatry, Shearer, et.al.; Correctional Service of Canada, 2004). Two studies have shown a correlation between the diagnosis of partial complex seizure disorder and histories of traumatic abuse (Epilepsy & Behavior, Gates, 2002; Medical College of Georgia, Murrow, 1997).

Amanda has some advice for people who support others, especially when there is a history of trauma involved. **Her advice is:**

Listen to us! I tried for years to tell people that I did not feel safe. Because I could not always put my feelings into words, I talked through my actions. You know that anger is a feeling that always comes after other feelings, but all people ever did was deal with my anger. Listen to the people you serve! Listen to their behavior, and if they are angry, find out why!

Don't hurt us! People hurt my wrists when they restrained me standing up, and it was even worse when they restrained me on the floor; it felt like I was being raped again and again. When I hurt other people, I never meant to hurt them, but I could not control myself.

Give us space! When people are angry, most of them want space, I never wanted people to be right next to me, but that is where they were! And the closer they got to me, the more I wanted to hit them because I was afraid they would hurt me.

Give us time! I ran away from lots of different homes, because I wanted time to blow up and then cool off. But people never gave me the time until LifeShare (the company that serves Amanda). They wrote a plan for me that said if I ran away they would not follow me, and if I did not come back in a certain time, they would call the police.

If you have to restrain people, tell them what you are doing and why. Sometimes people did not do that, they just restrained me and I did not know what they were doing, and it made me even more scared.

The rest of Amanda's story: Prior to LifeShare working with Amanda, she was restrained an average of 25 times per month. Since 2003, Amanda has never been restrained. She is now living in New Hampshire with no residential supports at all! She does receive some vocational supports, and is doing very well. The secret to her success was the healthy relationships formed with her by the staff of Lifeshare, Inc., and a positive behavior support plan that was focused entirely on one antecedent: keeping herself safe. Amanda is healing from her trauma. People ask if Amanda has healed, and the answer can be found in the quote below:

“Recovery from trauma is a journey, not an outcome”.

Kathy Regan, RN, MHA, CAN B.C.

“Healing Not Hurting Environments” presented at the
2007 American Psychiatric Nursing Association Conference

October 3, 2007, Orlando, FL

Escalation and De-Escalation

It is important to understand that escalation occurs when people feel threatened. People who have experienced significant trauma are “hyper-vigilant” at a **neurological level** due to the effects of trauma on a neurological level. (For more information on these effects, please see the articles on the CD-ROM.) Using Mandt System® terminology, people affected by significant trauma have a higher baseline and are more sensitive to threats to their safety. **De-escalation will only occur when people feel safe!** Verbally based de-escalation tools will have limited effect as discussed in Chapter 2 (Building Healthy Communication Skills) of The Mandt System®. To help people de-escalate, the relational and physical environments must be experienced by the individual as being safe.

NOTES:

Possible Effects of Restraint

We want to thank Kevin Ann Huckshorn and the National Technical Assistance Center for allowing us to utilize their material in this section.

The trauma experienced by people who were abused by the very people who were supposed to protect them can be devastating. There is an inherent fear that this will happen again, at the same time that there is a continuous hope that these people will somehow change, will somehow become the caring, nurturing people they are supposed to be.

For people who have experienced significant trauma, these feelings flood back into them at times when they have been restrained. A number of different studies have demonstrated that when people who have been traumatized are restrained, they are retraumatized. Some of them felt they were being punished, while in other situations they were confused by staff use of force, as these were the staff that just earlier had supported them positively. Others did not feel protected from harm, while some had feelings of bitterness and anger 1 year later. (*Wadson et al.*, 1976; *Martinez*, 1999; *Mann et al.* 1993; *Mohr*, 1999; *Ray et al.*, 1996)

One of the concepts discussed in Chapter 1 and presented in this chapter is the Crisis Cycle. People who have experienced significant trauma may have different “triggers” that move them from their baseline to the higher phases of the Crisis Cycle. It is important to understand two concepts:

1. People who have been traumatized will have a higher baseline; they are in continual states of hypervigilance, always on the lookout for things that could cause them harm.
2. Because of their hypervigilance, when they experience triggers, the behaviors they use in response are designed to maintain their own safety, and they will use those behaviors swiftly and with great force. As a result, they may appear to be angry and aggressive when in fact they are fearful and hurt.

Some of the triggers that may cause this quick escalation of behavior are:

Not being listened to	Lack of privacy	Feeling lonely
Darkness	Being teased or picked on	Feeling pressured
People yelling	Room checks	Loud noises
Being isolated	Being touched	Other (describe)
Not having control	Being stared at	

It is important to remember the model of the Crisis Cycle, and understand that when these triggers are experienced by people who have been severely traumatized, they will use behavior in some way to keep themselves safe. Many people display indicators that they are in a position where they may lose control. In Crisis Cycle terms, these are the transitional behaviors between Baseline phase and Escalation phase, and people are asking for help. Some of these behaviors include:

Clenching teeth	Crying	Giggling
Shaking	Singing inappropriately	Pacing
Heart pounding	Breathing hard	Shortness of breath
Clenching fists	Loud voice	Rocking
Can't sit still	Swearing	Restlessness
Wringing hands	Bouncing legs	

The strategies to use with people will vary from person to person. It is recommended that you get to know the person during the Baseline phase, and actually baseline the behaviors in which they engage when there is little or no stress. These are “self-reinforcing behaviors” and can be used in redirection or channeling feelings into activity strategies described in Chapter 2. Using a de-escalation preference tool can and should be a part of this process. **By using this approach, you may be able to help the person minimize the retraumatization which might otherwise occur.**

Another way to develop this list of strategies is to focus on safety. Ask people what helps them to feel safe. Some of the answers given to staff of the National Technical Assistance Center were:

Time alone	Therapeutic Touch, describe _____
Exercising	Eating
Writing in a journal	Taking a cold shower
Listening to music	Talking with staff
Molding clay	Calling friends or family
Reading a book	Pacing
Coloring	Hugging a stuffed animal
Taking a hot shower	Deep breathing
Being left alone	Talking to peers

There are responses staff may give which **may not be helpful to people**. Some of those responses are:

Being alone	Humor
Having many people around me	Staff not taking me seriously
Not being listened to	Being told to stay in my room
Loud tone of voice	Having space invaded
Peers teasing	

Notice that some of the responses on this list are also on the list of helpful responses. The responses must be individualized as different people will probably have different responses and different needs for support. In order to help people understand what may or may not help to provide safety and support, a de-escalation preference tool can provide the information needed to individualize responses.

The tool may reveal comments such as “I like to take medication only by mouth” or “the best way to support me when I am not feeling safe and may hurt myself or others is to give me a shot.” Some people may be able to tell you what medication they prefer, or if they prefer to have male or female staff work with them. You may also be able to help people identify how to best help them when restraint is necessary by asking if the person would rather have their hands held instead of a complete restraint. It is also important to consider racial, cultural, ethnic and/or religious factors.

Other factors to consider are things such as pre-existing medical conditions that may place people at risk; or physical disabilities/limitations that may place them at risk. Some people may not be able to communicate with staff when they are having difficulty managing their own behavior, and the question to ask ahead of time is “what can staff do at these moments to help people feel safe and supported?”

We highly recommend demonstrating the two types of physical restraint taught by The Mandt System® to people as part of the “de-escalation preference tool” process. There are several reasons for this recommendation: **(1)** Based on abuse history and gender, some people may prefer one restraint over another. **(2)** If people are aware of how they will be restrained, and give informed consent (or their guardian gives this), then any retraumatization may be minimized.

Again, we want to thank Kevin Ann Huckshorn and the National Technical Assistance Center for allowing us to utilize their material in this section.

Secondary Trauma

When staff use restraint, in whatever setting, the staff themselves may be traumatized. Secondary trauma refers to “professional workers’ sub-clinical or clinical symptoms of PTSD that mirror those experienced by trauma clients, friends, or family members.” (NCPTSD fact sheet) Secondary trauma is also known as vicarious Traumatization (Pearlman & Saakvitne, 1995) and compassion fatigue (Figley, 1995).

Some people who work with trauma victims become outwardly calloused and distant, while others use humor to deal with the feelings inside of them. All staff start out wanting to do their best, but over time can get to the point where they give less than their best because of the effects of secondary trauma. In many workplaces, there are Employee Assistance Plans to provide staff with support in the event they are traumatized in the course of their work.

Putting It All Together

Imposing restraint on people with whom staff have relationships can be difficult, especially in cases where injuries take place, and always when death occurs. Over time, the trauma can become overwhelming for staff, which is when they need the most support. One organization in Florida reported that one-third of the staff who resign within the first year of employment do so because they have a negative emotional response internally when they had to restrain the children served by the organization.

The use of any restraint (manual, physical, mechanical, or chemical) or seclusion must be seen not as part of a treatment plan but rather as a safety response. We want to emphasize that all restraints are traumatic events.

When a behavior analyst, therapist, nurse, counselor, teacher or similar professional writes a behavior support plan, a treatment plan, behavior intervention plan, etc., the purpose of the plan is to address the behavioral issues that in the past have led up to the use of restraint. If restraint is needed, it is not the personal “failure” of any one person. It is an indication that the support services provided to the individual did not, for some reason, prevent aggression towards self or others. In this case, we process and ask what we can do differently next time to improve in our ability to lower the frequency, duration, and intensity of restraint.



Resilience

Not all the people who experience interpersonal violence develop symptoms of Borderline Personality Disorder, Post Traumatic Stress Disorder, Partial Complex Seizure Disorder, etc. The term used to describe people who have these experiences and do not experience long term responses associated with trauma is *resilience*. “Resilience refers to the child’s ongoing efforts to tolerate, manage, and alleviate the psychological, behavioral, physiological, and social consequences of traumatic experiences. Effective adjustment includes no major deviation in the course of development and no long-term stress-related pathology” (Pynoos et al., 1995)

Some of the factors that may determine resiliency are:

- Family factors
 - Positive attachment to caregivers
 - Connections to other emotionally supportive adults
- Individual factors
 - Easy-going temperament
 - Internal locus of control
 - Positive coping strategies
 - Spirituality
 - (Werner & Smith, 1992)
- Community factors
 - Socio-Economic Status resources
 - Positive community organizations
 - Positive experiences with judicial system
 - (Masten & Coatsworth, 1998)

In a national analysis of how children can best be helped to recover from traumatic events, the development of healthy relationships was found to not only help the child socially and emotionally, but also to put them back on track for normal neurodevelopment. (Caldwell, 2005, Phelps, 2005). Dr. David Willis presented a paper at a conference in Oregon in 2006 in which he stated that children who experienced stable relationships were more likely to recover from trauma than children who did not have stable relationships. We can not stress enough the importance of healthy relationships between staff, as this serves as the context for services and provides a feeling of safety for the individual. **Chapter 1 of The Mandt System® is the most important chapter that we teach!**

Conclusion

Before proceeding to the next chapter, review the learning objectives found at the beginning of this chapter. Do you feel that you have accomplished each of the objectives listed there? If not, mark the objective(s) that you feel uncertain about and review the section of the lesson that corresponds to that objective. When finished, review the terms listed in the glossary. Since the chapters build upon one another, it is essential that you feel you have mastered the concepts and skills presented in this chapter before proceeding to the next.

Congratulations! You are at the end of this chapter, but there is certainly much more to learn on this topic. Our intent was to give you a brief overview of the topic of Trauma Support Services. Remember that it is your behavior as a staff person that will decide if situations are escalated or de-escalated, and people built up or torn down. Choose your behavior wisely!

Remember, one of the most important goals you can strive for in your job, home, or community is to develop a relationship with people, meet their needs, treat them with dignity and respect, as well as helping them keep their own dignity and respect for themselves.

A brief list of available resources on this subject follows:

<http://www.thecommunitycircle.org>

<http://www.NCPTSD.org>

<http://www.TraumaCenter.org>

<http://www.nasmhpd.org>

<http://www.dhfs.state.wi.us/aging/dementia/appendixK.pdf>

http://www.nctsnet.org/nccts/nav.do?pid=hom_main

²

All statistics cited can be found in *The Damaging Consequences of Violence and Trauma*, compiled by Ann Jennings, Ph.D. NTAC: 2004 and the NASMHPD Curriculum: *Six Core Strategies for the Reduction of Seclusion and Restraint*©, 2004.

Glossary of Terms

Acute Episodic Trauma - a traumatic event that occurs to individuals over which they have no control, and is often, though not always, the result of natural disasters.

Adverse Childhood Experiences (ACE's) - growing up (prior to age 18) in a household with one or more of the following: Recurrent physical abuse, recurrent emotional abuse, sexual abuse, an alcohol or drug abuser in the household, an incarcerated household member, someone who is chronically depressed, suicidal, institutionalized or mentally ill mother being treated violently, one or no biological parents, emotional or physical neglect.

Comprehensive Acute Traumatic Stress Management – a specific method of providing services and supports to people who have experienced some sort of trauma; designed by the American Academy of Experts in Traumatic Stress (AAETS)

Resilience - Resilience refers to the child's ongoing efforts to tolerate, manage, and alleviate the psychological, behavioral, physiological, and social consequences of traumatic experiences. Effective adjustment includes no major deviation in the course of development and no long-term stress-related pathology

Trauma from interpersonal violence - “the personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss, and the witnessing of violence.”

Trauma Informed Care – care that is grounded in and directed by a thorough understanding of the neurological, biological, psychological, and social effects of trauma and violence on humans and is informed by knowledge of the prevalence of these experiences in persons who receive mental health services.

Trauma Informed Services - incorporates knowledge about trauma, prevalence, impact, and recovery in all aspects of service delivery. Minimizes revictimization and leads to services that are hospitable and engaging to survivors

Trauma Specific Services - promising and evidenced based best practices and services that directly address an individual's traumatic experiences and sequelae and that facilitate effective recovery for trauma survivors

Self Study Questions

These self-study questions are provided to give you an opportunity to gauge your understanding of this chapter. Some or all of these questions will be used on the final exam.

- Check off all that apply:** A history of prolonged experiences to four or more Adverse Childhood Experiences can result in: (p 122-124; S15)
 - disrupted neurodevelopment
 - has no impact on any children.
 - disability, disease, and early death
 - adoption of health-risk behaviors
- The American Academy of Experts in Traumatic Stress recommends a three prong approach to dealing with what The Mandt System® terms Acute Episodic Stress. The three prongs are: (pp 117-119, SS 8-10)

- Fill in the Blanks** (one word each): The use of any restraint (manual, physical, mechanical, or chemical) or seclusion must be seen not as part of a treatment plan but rather as a _____ response. (p129 S 27)
- Check off all that apply:** Interpersonal Trauma is the personal experience of interpersonal violence, including: (p 122, S14)
 - sexual abuse
 - severe neglect
 - the witnessing of violence
 - hurricane
 - loss
- Fill in the Blanks** (one word each): Quoting a commonly used phrase, trauma informed services encourage supports and services that perceive responses to trauma as: "Normal responses to _____ situations."
(p 115, S5)
- Check off all that apply:** A de-escalation preference tool is recommended for use in asking people, when they are at their baseline, what helps to keep them safe. (p 128, S24)
 - talking with staff
 - listening to music
 - being told to stay in a room against their wishes
 - giving the person space
 - staff using a sarcastic tone of voice
- Fill in the Blanks** (one word each): Acute Episodic Trauma is when a person experiences a life threatening event over which he/she has no _____ .
(p115, S3)