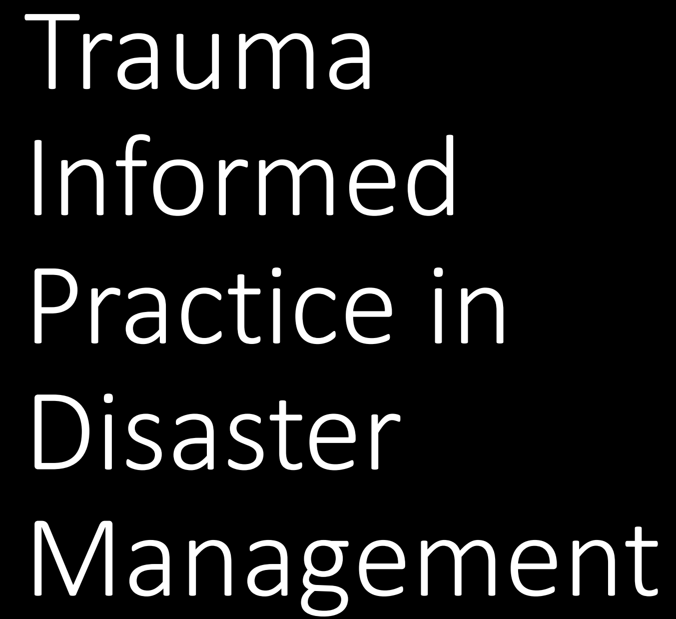
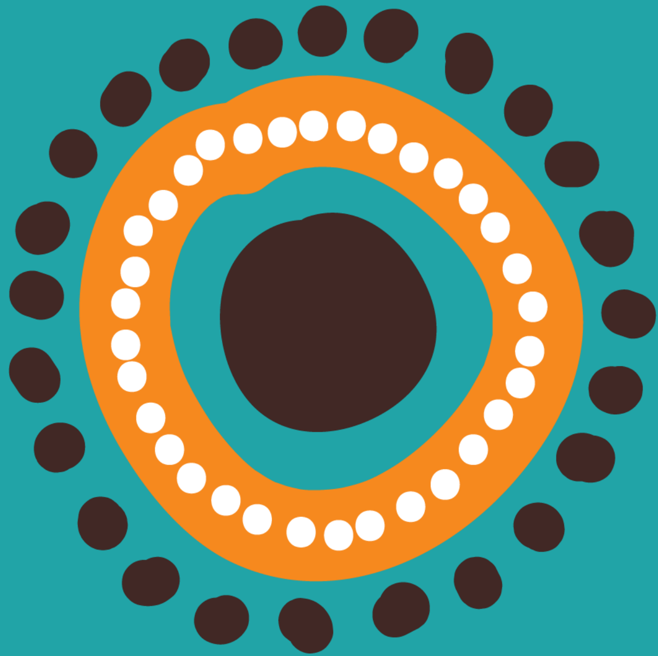


Trauma Informed Practice in Disaster Management

Rosie Gallagher

ADoN MHSS Education GCHHS

Acknowledgement to country



We would like to acknowledge the Yugambeh speaking people, the traditional owners of the land which we meet on today.

As we share our knowledge and learning with you, we would like to acknowledge and pay our respects to their elders past, present and emerging as it is their knowledge and experiences that hold the keys to the success of future generations.

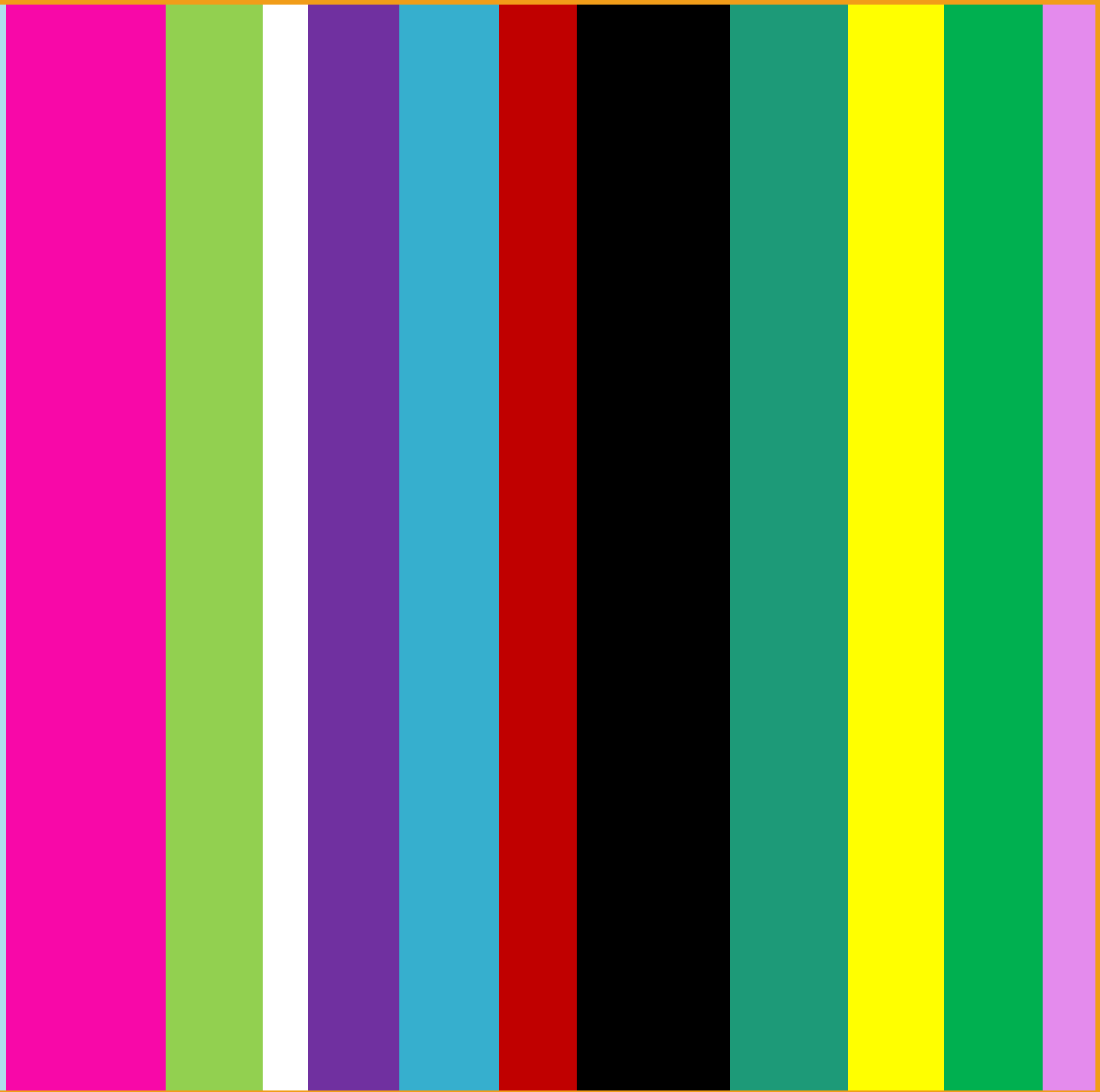
We would also like to acknowledge their ongoing connection to land, sea and community. This always was, and always will be their land.

We would like to acknowledge the universality of the trauma experience and welcome anyone in the room who has a lived experience of Trauma.

It is our intention today to ensure that you feel safe and cared for while you are learning

If any of the information becomes overwhelming at any point, please feel free to take a break

We would like to acknowledge the diversity of Australian society, including diversity in language, experience, worldview, cultural practice, gender and sexual identity. We also acknowledge the impact of a wide range of diverse trauma experiences, including from experiences of migration, family trauma, intergenerational trauma and the experiences of the Stolen Generation.



“People’s mental health and wellbeing following disasters is dependent on collaborative and well-coordinated action by all recovery partners”

(Australian Government National Mental Health Commission, 2023)

Section 1:
What do we mean by "trauma"?

DISCUSS:

Have a discussion with the person sitting next to you and make some notes together on the following question:

- What type of events may be relevant to consider when we are referring to “trauma”?

05:00

TRAUMA

Any single, ongoing or cumulative experience which is:

- A response to a perceived threat
- Overwhelms our capacity to cope
- Feels like it is outside of our control
- Evokes a psychological response, or a set of psychological responses based on fear or avoidance
- Induces a prolonged stress response

COMPLEX TRAUMA

The experience of multiple and, or, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature (e.g. sexual abuse) and early life onset.

(Bessel van der Kolk, 2005)

WHAT'S THE DIFFERENCE?

TRAUMA

Can occur at any stage of the lifecycle

Cognitive, social, emotional and language development has already occurred

Challenges capacity to cope

Enhanced stress response mechanism and reduced "window of tolerance"

COMPLEX TRAUMA

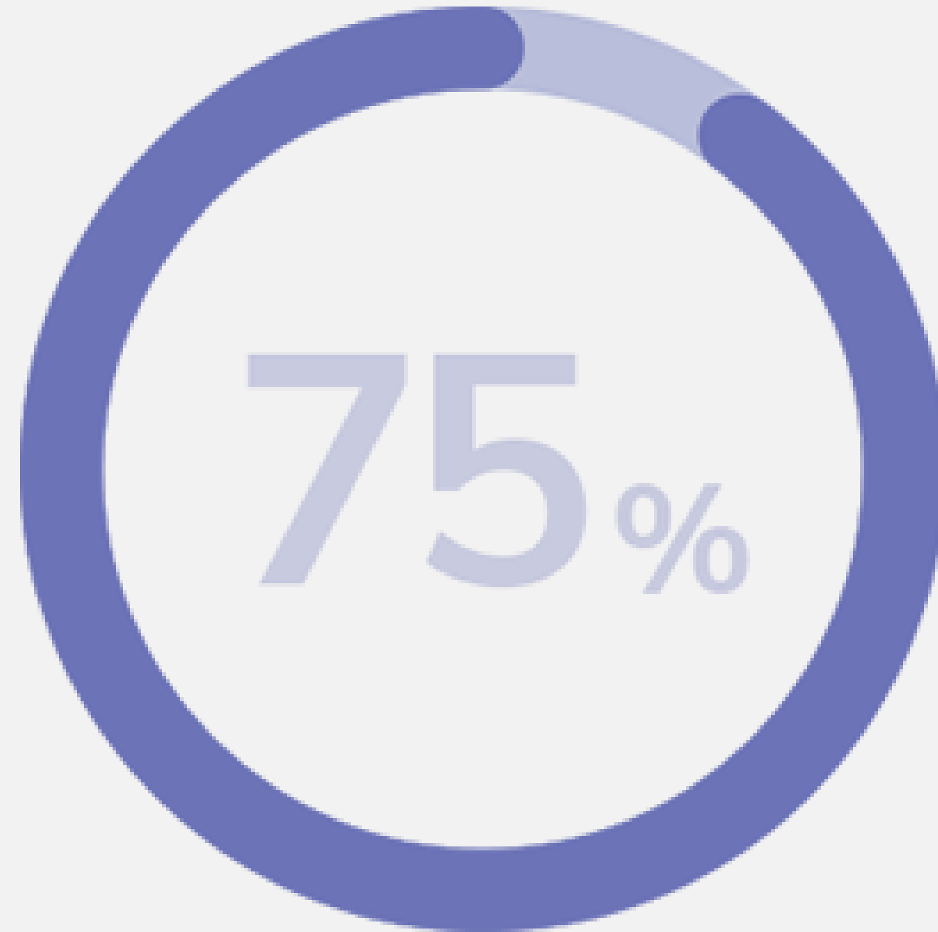
Occurs mainly in children 1- 5yrs

Critical to brain development including pre-language development

Overwhelms capacity to cope

Affects every area of development

AN ESTIMATED



OF GENERAL POPULATION

The CDC-Kaiser Permanente Adverse Childhood Experiences (ACEs) Study

Research Article

Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults

The Adverse Childhood Experiences (ACE) Study

Vincent J. Felitti, MD, FACP, Robert F. Anda, MD, MS, Dale Nordenberg, MD, David F. Williamson, MS, PhD, Alison M. Spitz, MS, MPH, Valerie Edwards, BA, Mary P. Koss, PhD, James S. Marks, MD, MPH

Background: The relationship of health risk behavior and disease in adulthood to the breadth of exposure to childhood emotional, physical, or sexual abuse, and household dysfunction during childhood has not previously been described.

Methods: A questionnaire about adverse childhood experiences was mailed to 13,494 adults who had completed a standardized medical evaluation at a large HMO; 9,508 (70.5%) responded. Seven categories of adverse childhood experiences were studied: psychological, physical, or sexual abuse; violence against mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. The number of categories of these adverse childhood experiences was then compared to measures of adult risk behavior, health status, and disease. Logistic regression was used to adjust for effects of demographic factors on the association between the cumulative number of categories of childhood exposures (range: 0–7) and risk factors for the leading causes of death in adult life.

Results: More than half of respondents reported at least one, and one-fourth reported ≥2 categories of childhood exposures. We found a graded relationship between the number of categories of childhood exposure and each of the adult health risk behaviors and diseases that were studied ($P < .001$). Persons who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4-fold increase in smoking, poor self-rated health, ≥50 sexual intercourse partners, and sexually transmitted disease; and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity. The number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The seven categories of adverse childhood experiences were strongly interrelated and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life.

Conclusions: We found a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.

Medical Subject Headings (MeSH): child abuse, sexual, domestic violence, spouse abuse, children of impaired parents, substance abuse, alcoholism, smoking, obesity, physical activity, depression, suicide, sexual behavior, sexually transmitted diseases, chronic obstructive pulmonary disease, ischemic heart disease. (Am J Prev Med 1998;14:245–258) © 1998 American Journal of Preventive Medicine

Department of Preventive Medicine, Southern California Permanente Medical Group (Kaiser Permanente), (Felitti) San Diego, California 92111. National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, (Anda, Williamson, Spitz, Edwards, Marks) Atlanta, Georgia 30333. Department of Pediatrics, Emory University School Medicine, (Nordenberg) Atlanta, Georgia 30333. Department of Family and Community Medicine, University of Arizona Health Sciences Center, (Koss) Tucson, Arizona 85727.

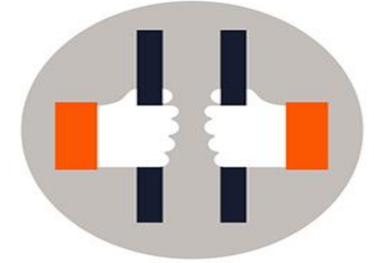
Address correspondence to: Vincent J. Felitti, MD, Kaiser Permanente, Department of Preventive Medicine, 7060 Clairemont Mesa Boulevard, San Diego, California 92111.

Am J Prev Med 1998;14(4)
© 1998 American Journal of Preventive Medicine
0749-3797/98/$19.00 245
PII S0749-3797(98)00017-8

About the CDC-Kaiser ACE Study

The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study is one of the largest investigations of childhood abuse and neglect, household challenges and later-life health and well-being.

- Originally conducted from 1995 to 1997
- Two waves of data collection.
- Over 17,000 Health Maintenance Organization members from Southern California receiving physical exams completed confidential surveys regarding their childhood experiences and current health status and behaviors.

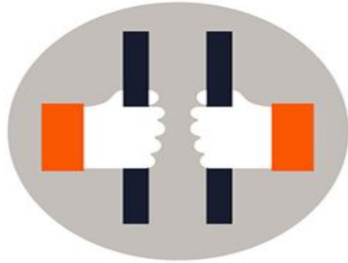
ABUSE	NEGLECT	HOUSEHOLD DYSFUNCTION	
Physical	Physical	Mental Illness	 Incarcerated Relative
Emotional	Emotional	Mother treated violently	Substance Abuse
Sexual		Divorce	

DISCUSS:

- With your partner, discuss what you think the prevalence of ACES in Australia might be
- Why do think this?

05:00

Prevalence of ACEs in Australia



Nearly half (**47%**) of the approximately 1.25 million people in state prison are parents of minor children, and about 1 in 5 (19%) of those children is age 4 or younger (Prison Policy Initiative)

In 2019 14.5% of parents across Australia reported use of any illicit drug (including pharmaceuticals for non-medical purposes) (AIHW, 2022)

Prevalence of ACEs in Australia

In 2020, 17% of parents with children aged 0-14 years reported having a mental health problem (AIHW, 2022)

In 2016, 86.8% of Australian adults reported experiencing current partner violence that was heard or seen by their children in the previous 12 months (AIHW, 2022)

In 2020, The proportion of divorces involving children under 18 years was 49%. This does not include separations of cohabiting couples with or without children (AIFS, 2022)

Prevalence of ACEs in Australia

NEGLECT

Physical

Emotional

In the 2011-12 financial year there were 10,936 Australian children with substantiated reports of harm or risk of harm due to child neglect (AIHW, 2013)

Neglect was the second most commonly substantiated form of maltreatment (31%) nationally after emotional abuse

At a State-wide level, Neglect is the most commonly substantiated form of maltreatment for New South Wales, Queensland, South Australia, the Australian Capital Territory, and Northern Territory (AIHW, 2013).

Prevalence of ACEs in Australia

ABUSE

Physical

Between 50% and 80% of Australian parents report using physical punishment of varying degrees to discipline their children (Poulsen, 2019). Physical abuse may be intentional or may be the inadvertent result of physical punishment. Physically abusive behaviours include shoving, hitting, slapping, beating, shaking, throwing, punching, kicking, biting, burning, scalding, strangling, poisoning and suffocating the child (AIFS, 2017)

Emotional

Emotional maltreatment can consist of both acts of commission (e.g., verbal abuse) or omission (e.g., withholding of affection or attention). A number of recent Australian studies estimate the rates of emotional abuse to range between 14%-17% (AIFS, 2017)

Prevalence of ACEs in Australia

ABUSE

Sexual

The Australian Child Mistreatment Survey (2023) is the first nationally representative study of child maltreatment. It found that:

- 28.5% of Australians experienced child sexual abuse
- Girls experience double the rate of child sexual abuse (37.3% versus 18.8% of boys)
- Almost 1 in 4 Australians experienced one or more types of contact child sexual abuse (23.7%)
- Almost 1 in 5 experienced non-contact child sexual abuse (18.1%)
- Almost 1 in 10 Australians experienced forced sex in childhood (8.7%) (Mathews, Pacella, Scott, et al., 2023)

According to the most recent Australian Bureau of Statistics Personal Safety Survey (ABS, 2022), 11% of women (1.1 million) and 5% of men (343,000) in Australia report having been sexually abused before the age of 15 years.

DISCUSS:

- With your neighbour, discuss why you think the information on ACEs prevalence in Australia may be relevant to disaster response.

05:00

Section 2:

Impacts of trauma on the brain and the body

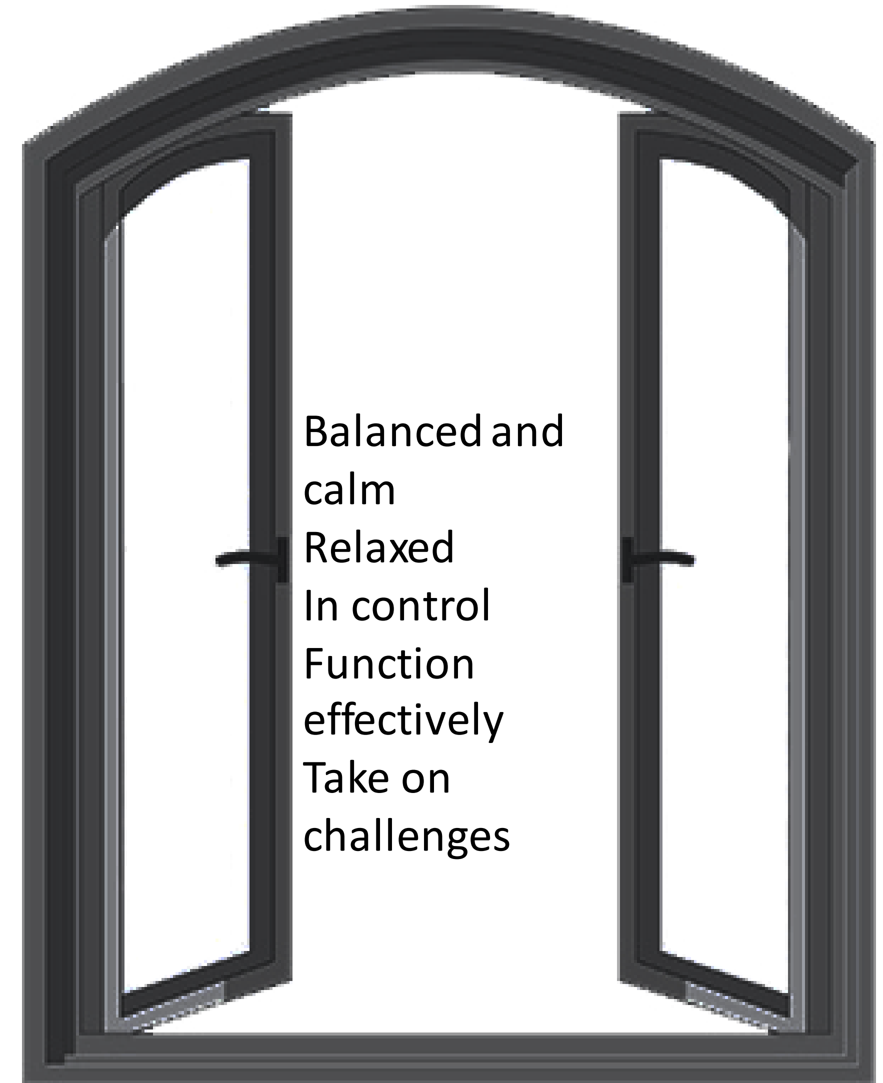
Window of Tolerance

Our **Window of Tolerance** describes an **optimal zone** where we can process **intense emotions** that cause stress or anxiety in a **regulated** way.

It allows us to respond to the demands of life **without difficulty.**

Our window is a **comfortable place** where we can **self-soothe** and **self-regulate.**

Traumatic experiences and **toxic stress** can push us **out of our window of tolerance** and can even make it **hard to get back in the zone**



Window of Tolerance

Hyperaroused State
- Fight/flight response
- Emotional reactivity
- Sweaty palms, increased heart rate
- Difficulty concentrating
- Panic, rage
- Hyper-vigilance

Optimal Level of Functioning
- Present, Calm and Safe
- Can think and respond clearly
- Engaged and alert

Hypoaroused State
- Freeze response
- Lethargic, low energy
- Numb, Lack of emotions
- Little to no physical movement
- Zoning out, dissociation
- Shut down

When the fine balance is disrupted, we begin to **dysregulate** and will experience a **heightened flight or fight** response. This is sometimes referred to as **"Hyper-arousal"**

If we are not able in the moment to fight or flee, our bodies can enter the **freeze state**. This can be referred to as **"Hypo-arousal"**

Our window is a **comfortable place** where we can **self-soothe** and **self-regulate.**

DISCUSS:

- With your neighbour, discuss some of the ways that *you* respond when you feel stressed or distressed
- Think about physical symptoms, but also any changes that might occur in *your* thinking and *your* behaviour

05:00

SOCIAL ENGAGEMENT SYSTEM
(VENTRAL VAGAL)

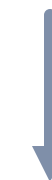
Increases:
Digestion, Intestinal motility, Immune Response, Circulation to non-vital organs, Oxytocin, Ability to relate and connect

Decreases:
Defensive Responses

SYMPATHETIC NERVOUS SYSTEM:

Increases:
Blood Pressure, Heartrate, Adrenaline, Oxygen circulation to vital organs

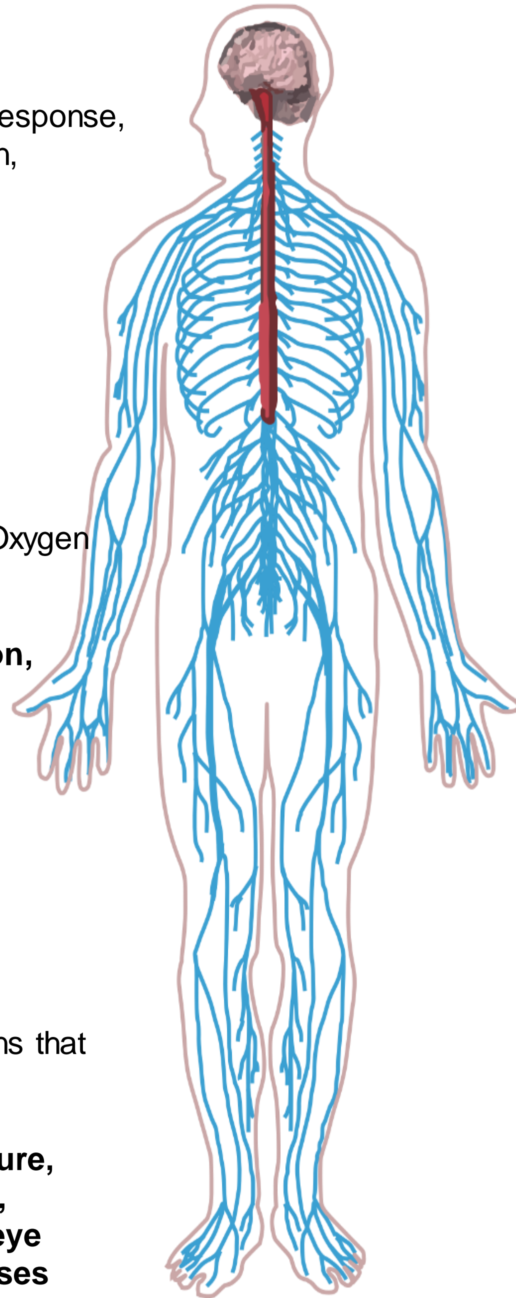
Decreases:
Fuel storage, Insulin Activity, Digestion, Relational Ability, Immune Response



PARASYMPATHETIC SYSTEM
(DORSAL VAGAL):

Increases:
Fuel Storage & Insulin Activity Endorphins that help numb and raise the pain threshold

Decreases:
Heart rate, Blood Pressure, Temperature, Muscle Tone, Awareness of the voice, Social Behaviour, facial expression, eye contact, Sexual and Immune Responses



SOCIAL ENGAGEMENT SYSTEM

SAFE

Social connection: Soft voice, eye contact, soothing tone, engagement

MOBILISATION
: Work, sport, social connection, intimacy, relationships

IMMOBILISATION:
Rest, sleep, rejuvenation, relaxation

SAFE

NEUROCEPTION

Negotiation, appeasement, survival, oppression of others, denial, lying, passive aggression, manipulation, control

DANGER

THREAT

FIGHT

FLIGHT

NEUROCEPTION

LIFE THREAT

FREEZE
FAINT
DISSOCIATION
SHOCK

HYPerAROUSAL

It is highly adaptive for a person who has grown up in a violent or dysfunctional environment to be hypervigilent, and to be in a persistent stress-response state.

The ANS can become "over-stretched" when exposure to traumatic events is continuous and the body becomes particularly sensitive to stress-inducing experiences

SIGNS OF HYPERAROUSAL

Fight or flight
Anxiety
Panic
Overwhelm
Hyperactivity
Anger
Inability to relax
Sleeping problems
Difficulty concentrating
Destructive behaviour
Easily startled
Hypervigilant
Rapid breathing

@PSYCHOTHERAPY.CENTRAL

HYPoAROUSAL

Child neglect and chronic under-stimulation of the child during key neurodevelopmental periods may result in states of ongoing HYPO-arousal.

Hypoarousal arising from traumatic events has been linked with some affective disorders, an undeveloped ability to empathise and adolescent anti-social behaviours (Murphy et al., 2022)

Behaviourally, hypo-arousal may be observed as under-responsiveness to stimuli and one's environment

(Tinajero et al., 2020)

SIGNS OF HYPOAROUSAL

Low energy
Exhaustion
Numbness
Shut down
Depression
Disconnection
Freeze
Dissociated
Unable to think clearly

@PSYCHOTHERAPY.CENTRAL

The act of separation or disconnection from immediate experience. Dissociation varies in type and intensity, along a continuum.

Can occur in unremarkable forms such as daydreaming and mild trancing or in more severe forms with significant consequences such as grand mal seizures and dissociative fugue states

As a defensive response to overwhelming threat, dissociation is commonly present to varying degrees as a dimension of trauma…

Because of its prevalence as a feature of trauma, effective trauma treatment requires knowledge of and ability to work with dissociative responses

(Kezelman & Stavropoulos, 2019, p.102)

At its most extreme, dissociation can result in a “shut-down” state characterised by dense trance, increase in pain threshold and stupor – even to the extent of catatonic-type presentations

(Loewenstein, Frewen & Lewis-Fernandez, 2017)

Dissociation (continued)

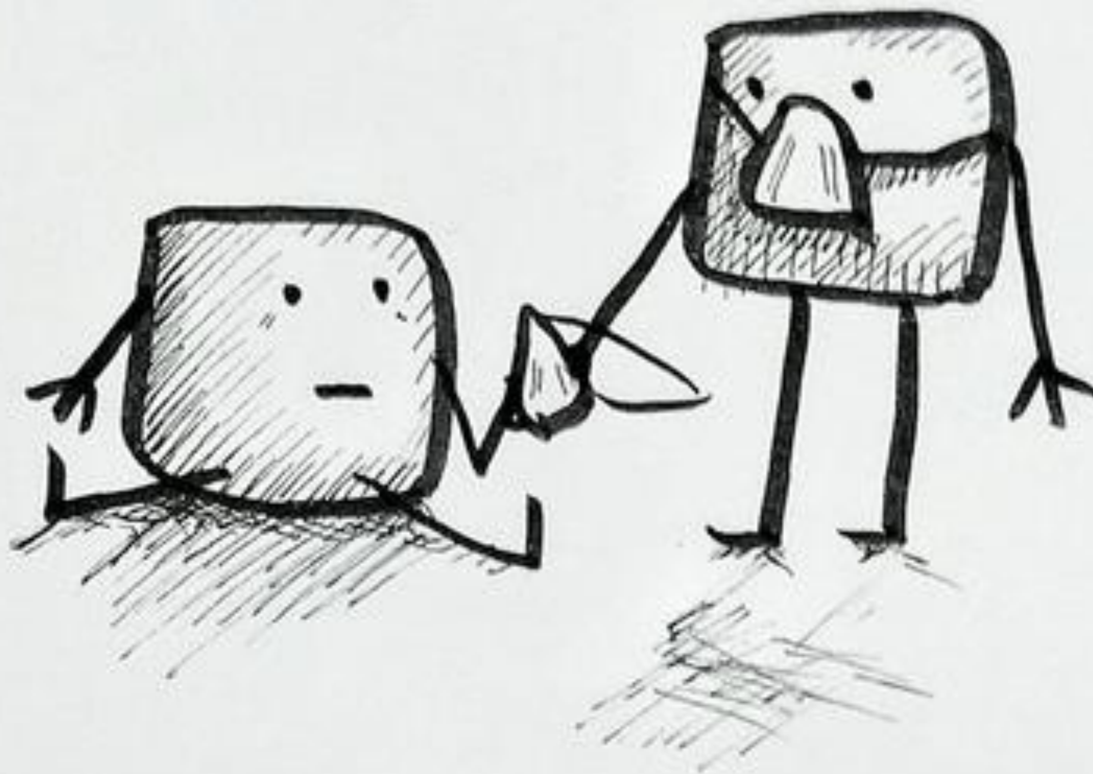
- *Dissociation occurs beyond conscious, awareness and control.*
- *It can also be reflexively deployed subsequent to the precipitating trauma in the absence of apparent threat.*
- *That is, it can be activated by seemingly innocuous cues which serve as 'triggers' of the trauma.*

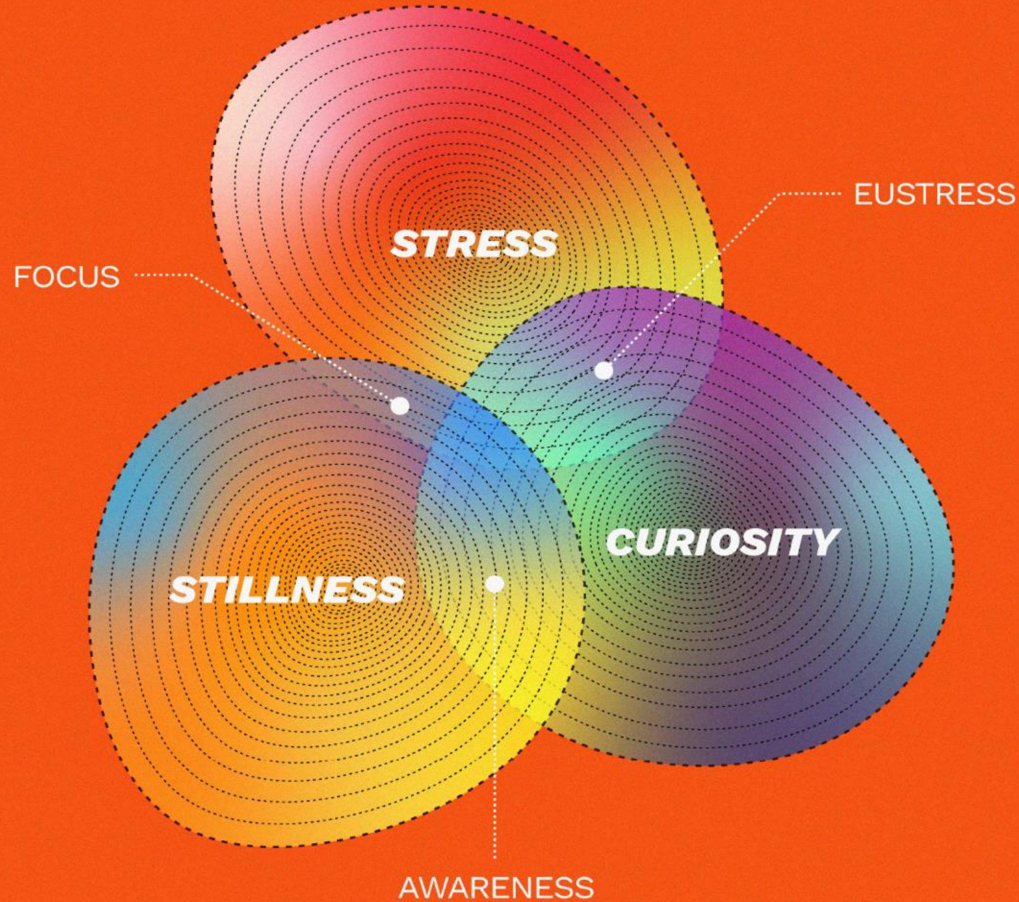
(Kezelman & Stavropoulos, 2019, p.102)

Section 3:
Helping those
experiencing trauma

Start with YOU!

put your own oxygen mask on first





Emotions are contagious – we catch them like a cold

Emotional contagion occurs when someone's emotions and related behaviours lead to similar emotions and behaviours in others.

Awareness of emotional contagion is important for managing our *own* emotions and related actions, and to assure our wellbeing and that of others.

DISCUSS:

- With your neighbour, discuss why “emotional contagion” may be relevant to disaster response

05:00

FIRST STEP:

- Control *yourself* FIRST
- Learn to recognise your own stress response
- Learn to manage it using emotional regulation techniques that work for YOU

Control yourself FIRST

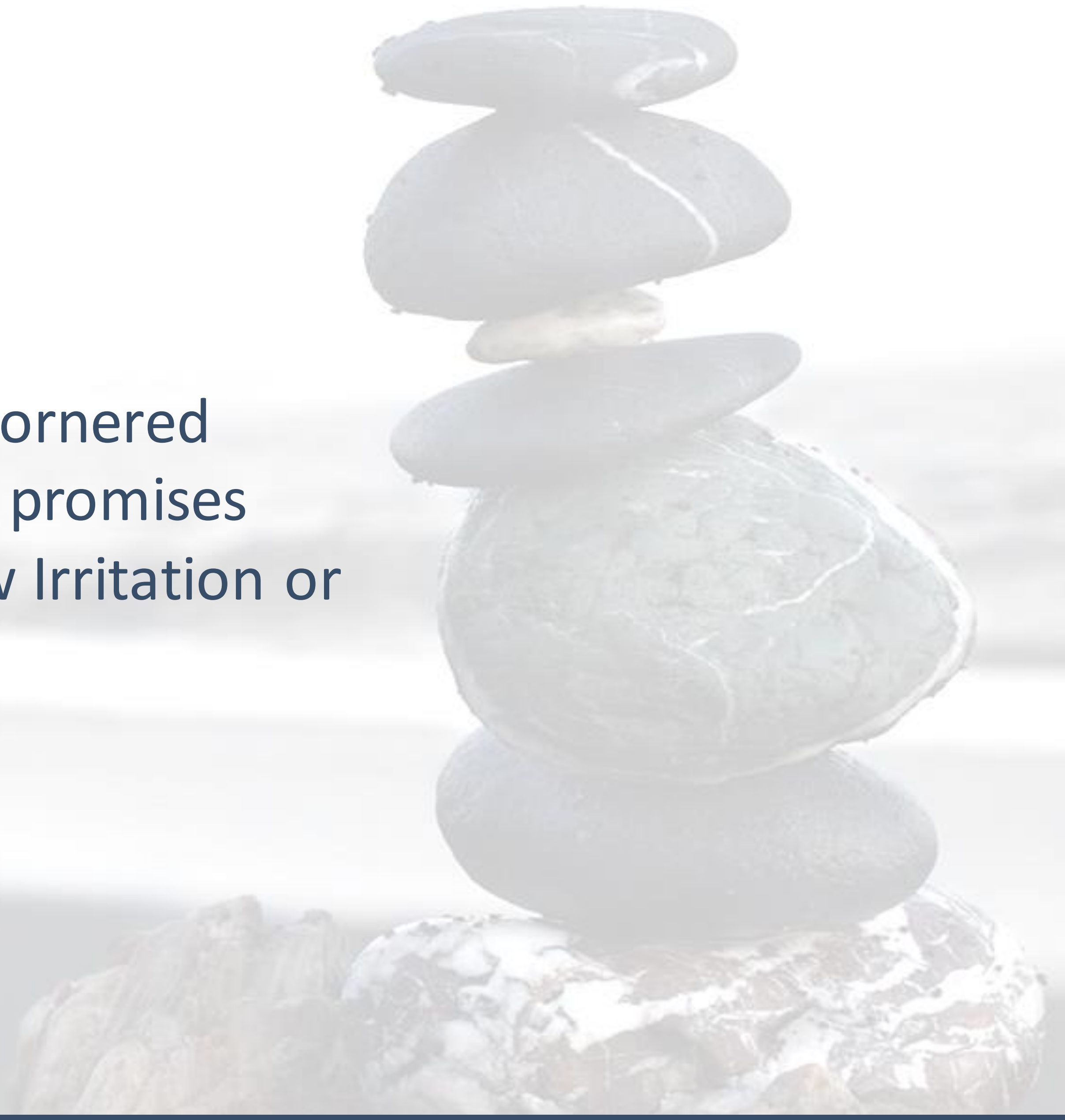
A **dysregulated responder** cannot assist others to regulate **their emotions**

The <u>only</u> aspect of a crisis situation that you have *absolute* control over is **how you respond to it**

YOUR ANXIETY REACTION- WHAT IS IT?

AIM TO CONTROL:

- Your Actions
  - Act Calmly and Confidently
  - Don’t make the person feel cornered
  - Don’t threaten or make false promises
  - Do not: Judge, Criticise, Show Irritation or frustration
  - Do not be retaliative EVER

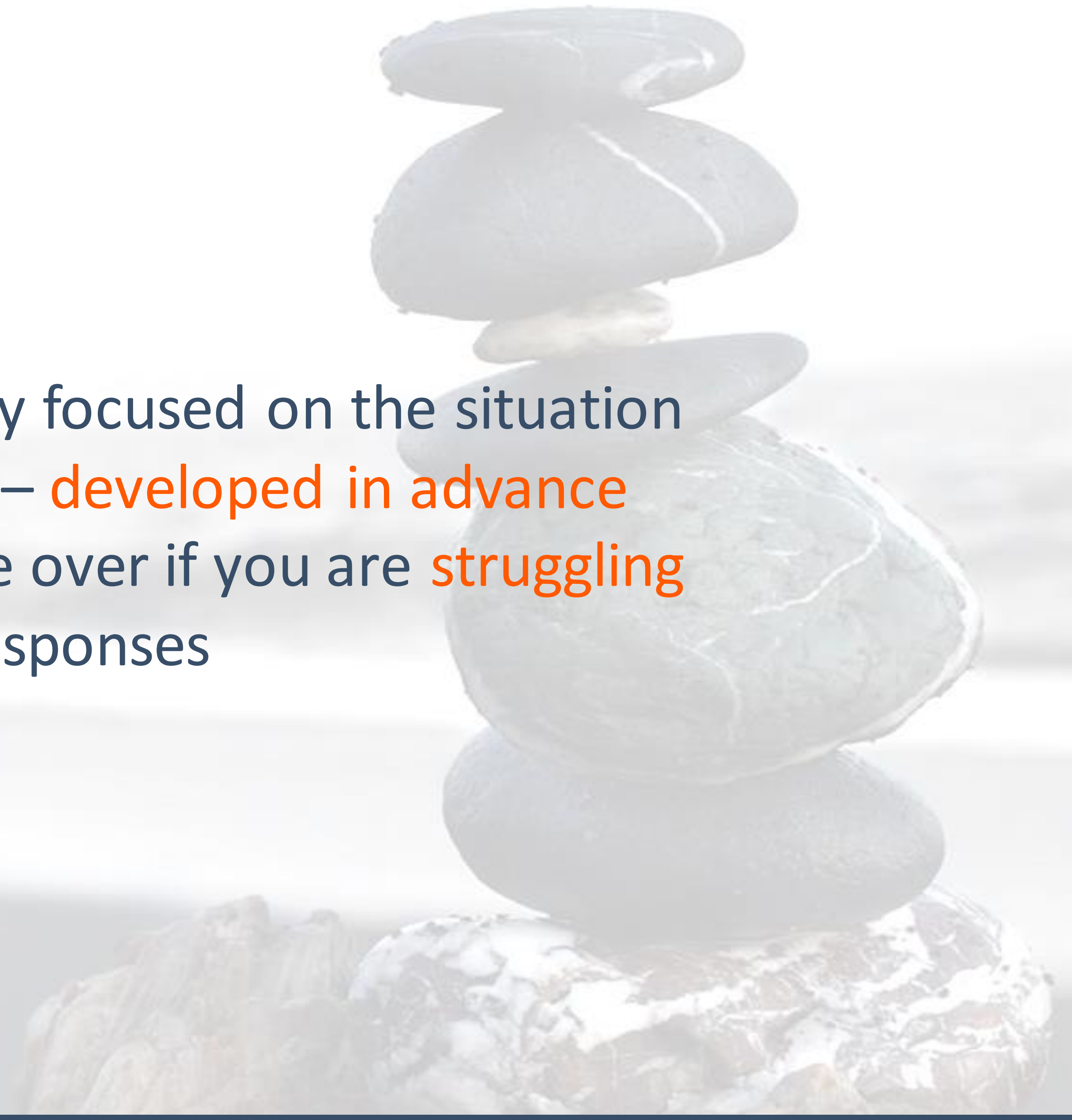


AIM TO CONTROL:

- Your Body Language/Non-verbals
  - Use slow and gentle movements
  - Notice what your facial expression is doing – don't frown or purse lips
  - Try to relax your body – avoid hands-on hips or in pockets
  - Keeps arms lowered and uncrossed
  - Keep hands open and where they can be seen

AIM TO CONTROL:

- Your verbal communication
  - Avoid hesitancy or uncertainty in your speech
  - Do not argue or tell the person they are wrong
  - Do not react to verbal insults or abuse – it is rarely about you
  - Ignore insults, or even partially agree
  - Prepare yourself to not react in the face of insults or anger



AIM TO CONTROL:

- Your emotions
  - Breathe deeply and try to stay focused on the situation
  - Utilise stress relief strategies – developed in advance
  - Ask another colleague to take over if you are struggling to manage your emotional responses

…before helping others:

Working with dissociation

Dissociation is a type of "experiential avoidance". Most commonly manifests as:

- Emotional numbing
- Limited awareness of and ability to contact feelings, emotions, sensations.
- A sense of numbness, "emptiness" or "deadness" in the body.

"Freeze" is a full-body response – if dissociation occurs, the whole body will follow

Working with dissociation

HOW DO I RESPOND TO THE FREEZE/DISSOCIATION COMBINATION?

Steps TO HELP:

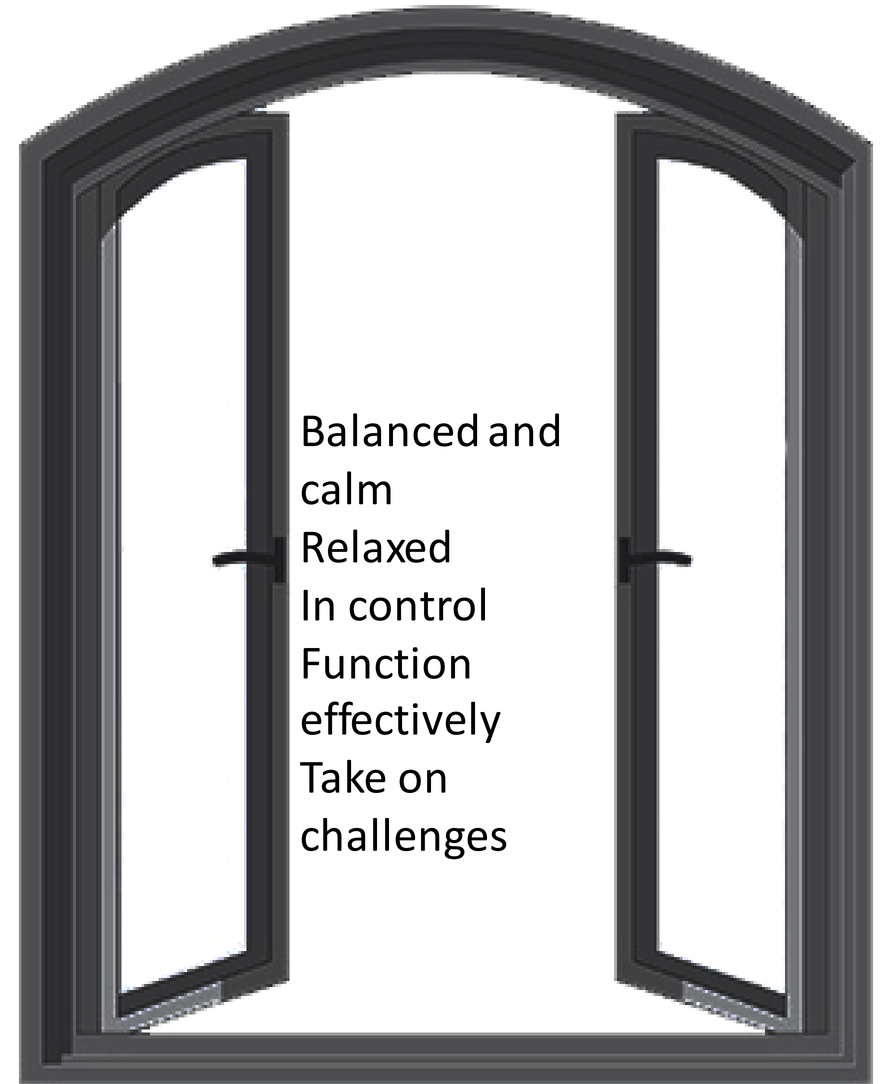
1. **Normalise** and **Validate**
   - "This is a *normal* response to *abnormal* circumstances"
2. Aim to **Clarify** what is happening – People do not choose to dissociate – it is an involuntary, protective response
   - "It is your mind and body trying to protect you from intensely painful events"
3. Get **Present**
   - Offer/suggest mindfulness techniques to help the person reconnect with the present so that you are able to assist them more effectively
   - "Holding Space" – If the person is unable to respond to you, just sitting with them and being there for them can be the most helpful thing to do
   - Use of small sensory tools or items that are comforting/familiar
   - See/Hear/Smell/Taste/Touch

Working with Hyper-arousal

An ongoing threat, the accumulation of excessive stress, or traumatic experiences can disrupt an individual's ability to stay within their Window of Tolerance, causing them to become overwhelmed

Because of this, the person may exhibit symptoms of anger, anxiety or panic.

They may *even* "flip their lid"

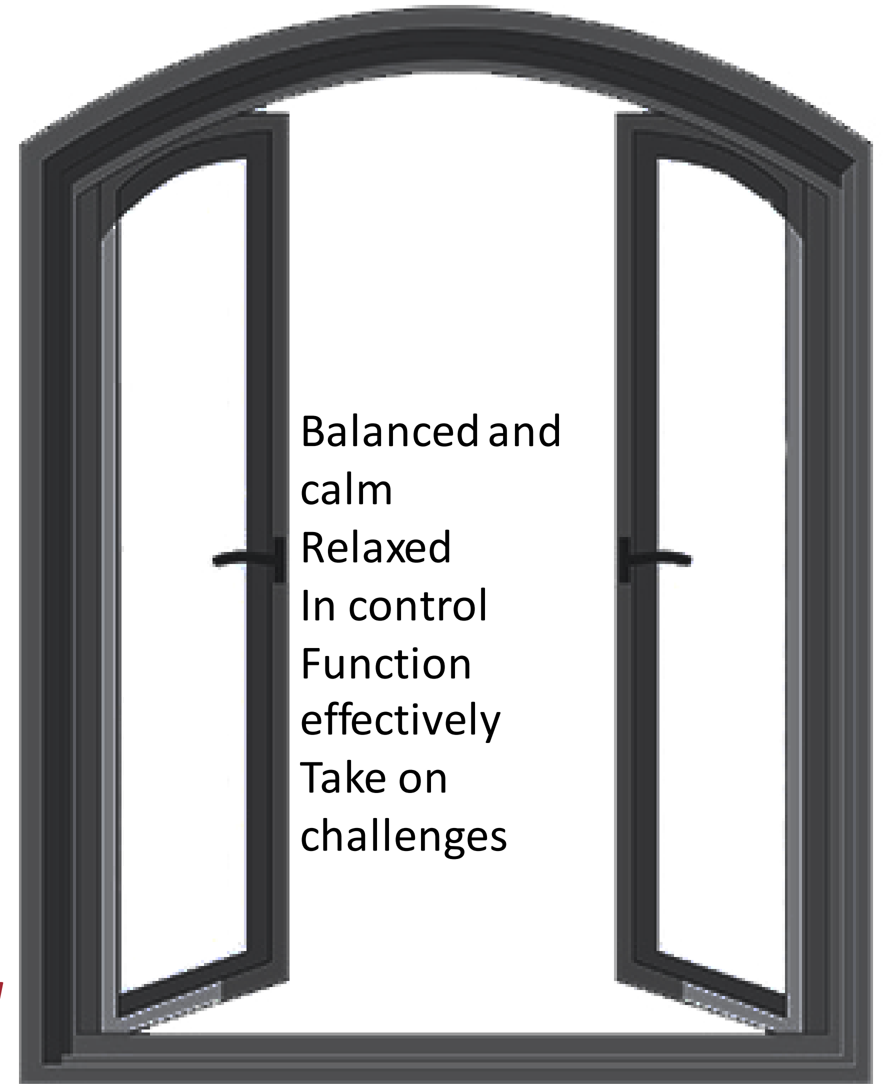


The Hand Model of the Brain

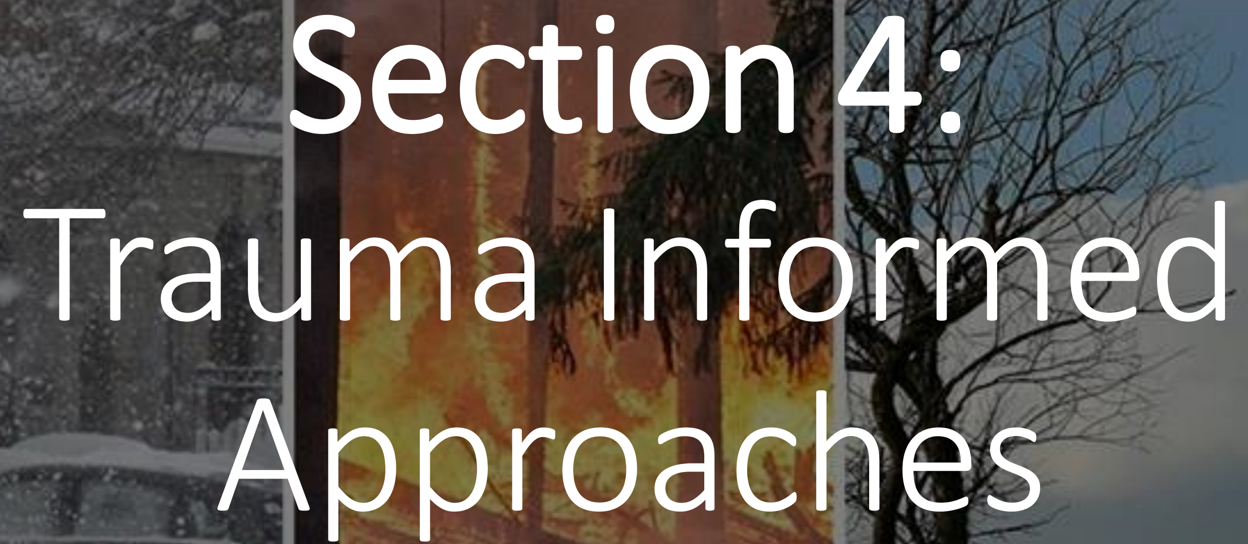
Adapted and presented by Emotion Coaching UK

Working with Hyper-arousal

- Soothing Breath – “Tummy” or “Belly” breathing
- Shaking/Stomping – can provide an outlet to burn off anxious energy prior to engagement
- Extremes of temperature – warm or very cold showers can be helpful to calm the ANS
- Rhythmical movement – rocking/swaying
- Food and Drinks – e.g. hot chocolate/chewy sweets
- Weighted/multiple blankets
- Distraction techniques
- Soothing and gentle voice/tone ↓
- REMEMBER: Emotional contagion can also be *helpful* to this process



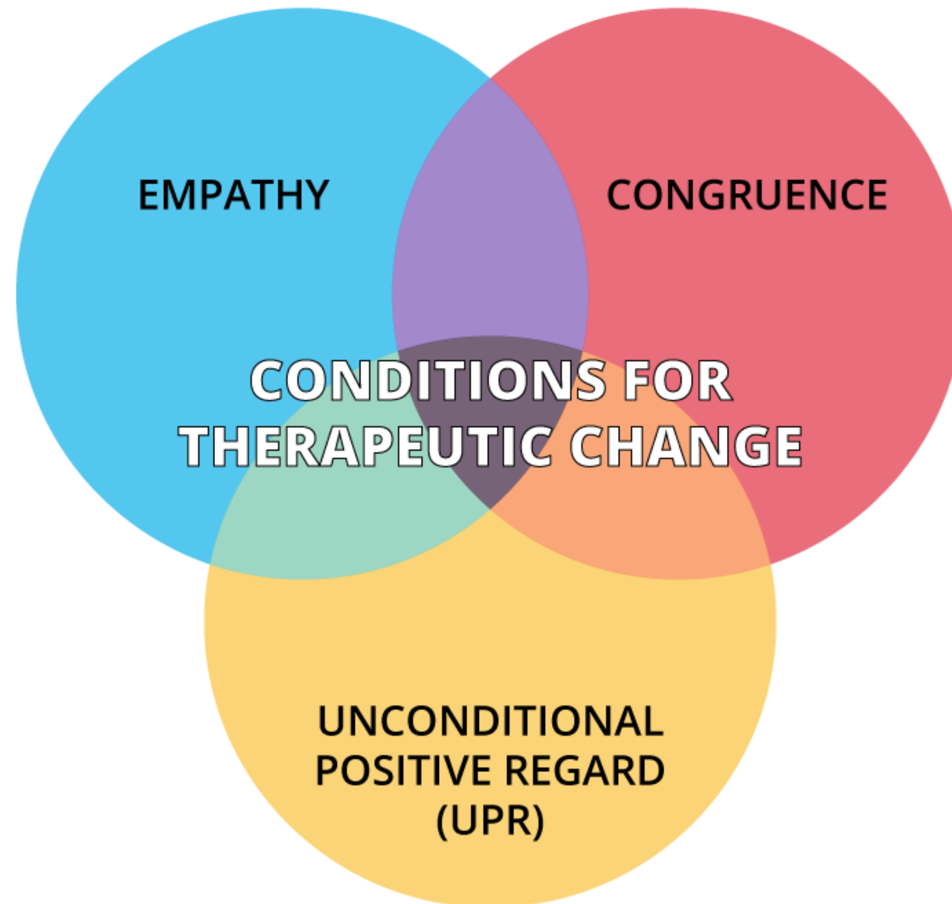
Section 4:
Trauma Informed Approaches



Principles of Trauma Informed Practice

SIX GUIDING PRINCIPLES TO A TRAUMA INFORMED APPROACH

Therapeutic Engagement



Carl Rogers (1951) defined 3 clear components relevant to the development of good therapeutic connections

"A purposeful and willing relationship between at least two people, one who is supposed to know what he is doing, to the other who wants help to change his life for the better."
(Rivera, 1992, p.52)

In order to support people effectively, developing connections early and strengthening them throughout the engagement process are important.

The development of a good therapeutic connection is essential for the delivery of care and support that is informed by a knowledge of trauma

Robust and professional therapeutic connects help to engender trust, collaboration, mutuality, empowerment and support voice and choice

“Before every session, I take a moment to remember my humanity. There is no experience that this man has that I cannot share with him, no fear that I cannot understand, no suffering that I cannot care about, because I too am human.

No matter how deep his wound, he does not need to be ashamed in front of me. I too am vulnerable. And because of this, I am enough. Whatever his story, he no longer needs to be alone with it. This is what will allow his healing to begin.”

Carl Rogers

THE 4 Rs

A program, approach or system that is "trauma-informed" aims to:

1. REALISE
the widespread impact of traumatic experiences and understand potential paths to recovery

2. RECOGNISE
the signs and symptomology of trauma in clients, families, staff and others within the system/service

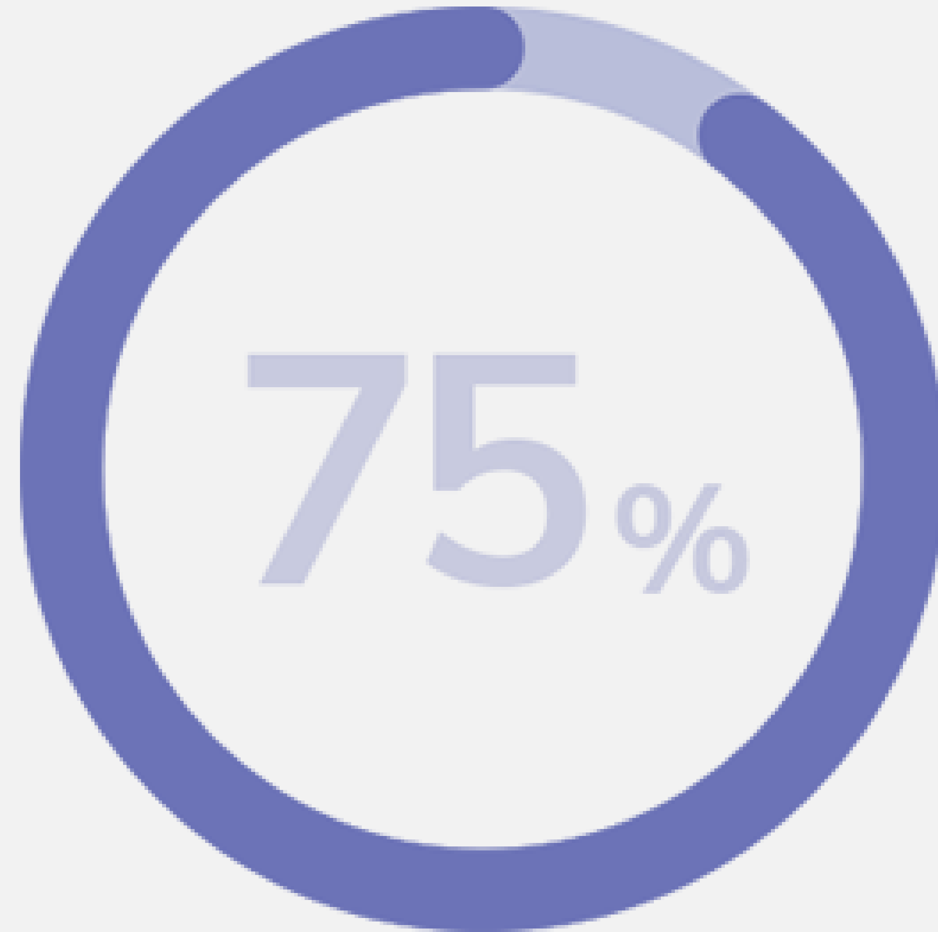
3. RESPOND
By fully integrating knowledge about trauma into policies, procedures and practices and seeks to actively…

4. RESIST
Retraumatising the individual by ensuring that treatments and interventions "do no harm"

In Practice – this can look like:

- Always seeking to avoid re-traumatisation by **Empowering** individuals in decision-making about the support and input they need
- Creating and promoting feelings of **Safety** (but REMEMBER safety is subjective to the person)
- Building **Trust**
- Offering **Choices** and options where possible and
- **Collaboration** *with* the person or community to ensure that responses are tailored to need
- Ensure that family/friends/community are involved where appropriate in providing support for the person.

AN ESTIMATED



OF GENERAL POPULATION