A Trauma informed service – from NICE guidelines to actuality

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Patients and Staff at The Farndon Unit

The Farndon Unit - Overview

- 48 bedded female low secure unit, 5 wards
- High population of patients with history of traumatic experiences
- Co-morbid presentations
- High levels of shame, self-criticism, self-blame, self harm and suicidal behaviour
- Experiences of moving around to different hospitals or being ‘in and out’ of different services (underlying trauma not being recognised)

Complex PTSD – ICD -11

PTSD

- Re-experiencing (nightmares, flashbacks)
- Avoidance (thoughts, feelings, places, people associated with the trauma)
- Sense of current threat (hypervigilance or an enhanced startle reaction)

Complex PTSD includes:

DSO (Disturbances in Self-Organization)

- Emotions - Affect Dysregulation, anger, recklessness, numbing, and dissociation
- Identity - Negative Self-Concept (feeling diminished, defeated and worthless, feelings of shame, guilt, or despair)
- Relationships - Difficulties engaging and maintaining relationships, difficulties in feeling close to others.

Phase – Based Approach to Trauma Therapy

- Several studies suggest a phased approach to trauma treatment is beneficial (Cloitre et al.,2014). This is especially recommended for people with severe difficulty in regulating emotions, self-harm or suicidal behaviour or significant dissociation) (NICE Guidelines, 2018)

- Treatment should not unnecessarily delayed or avoided. However, the duration and content of the phases should be individualised and take account of their risk behaviours and ability to regulate emotions. (NICE Guidelines, 2018).

- Where there has been recent self harming or suicidal behaviour, it is recommended that a stabilisation and psychoeducation phase be included (NICE Guidelines, 2018).

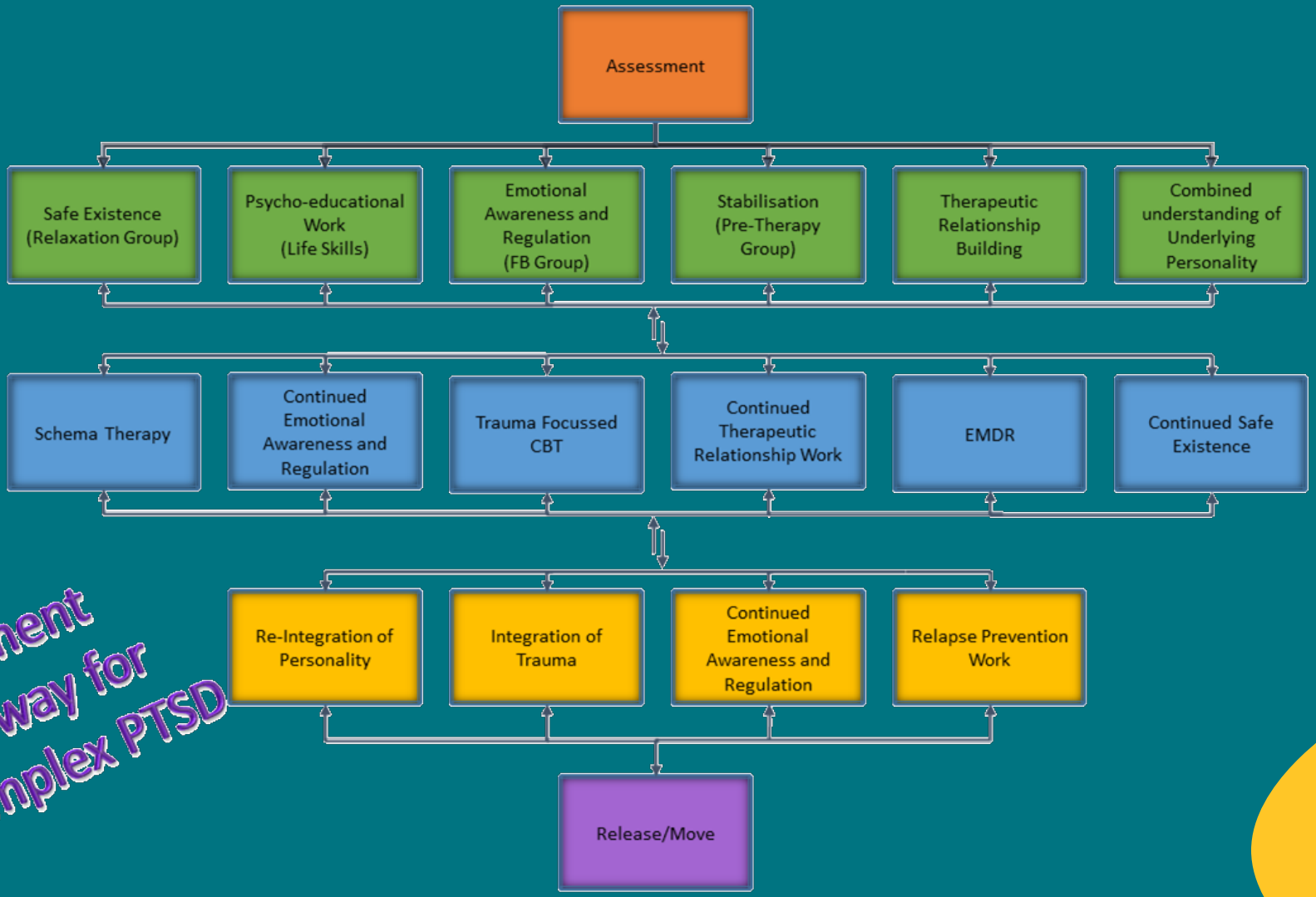
A Phase Based Approach (Herman, 1992)

The phase-based model (Herman, 1992), involves three overlapping phases of treatment:

- Phase one: stabilisation (establishing safety, symptom management, improving emotion regulation and addressing current stressors)
- Phase two: trauma processing (focused processing of traumatic memories)
- Phase three: reintegration (re-establishing social and cultural connection and addressing personal quality of life).

The phases are likely to be cyclical and the individual may need to return to earlier phases as therapy progresses.

Complex PTSD Treatment Pathway



Treatment Pathway for Complex PTSD

Phase 1 – Stabilisation and Psychoeducation

Following assessment and formulation – phase 1 includes stabilisation and psychoeducation:

1. Establishing a therapeutic relationship
2. Psychoeducation
3. Establishing safety and readiness for therapy (care plans)
4. Grounding for dissociation/flashbacks
5. Symptom management
6. Skills training
7. Compassion-focused therapy

Phase 1 – Stabilisation and Psychoeducation

1. Establishing a therapeutic relationship

- Trauma, especially when it is interpersonal, can make forming and maintaining relationships more difficult. Mistrust, emotional lability, and relational instability in response to traumatic experiences can therefore impact on the formation of therapeutic relationships.

- Offering a choice of therapist that takes into account the person's trauma experience e.g. gender of therapist is important (NICE Guideline recommendations, 2018)

- Therapeutic relationship are also needed with ward staff and other members of the MDT so that the patient feels supported prior to and after a trauma therapy session

- *"I had trust in my therapist, building the therapeutic rapport helped to bring my guard down"*

Phase 1 – Stabilisation and Psychoeducation

2. Psychoeducation

- Models of trauma
- Window of tolerance
- Dissociation
- Symptoms and emotional responses
- CFT and biology

3. Establishing safety and readiness for therapy

- Safety includes ward based safety and MDT support
- Care plan

"I [had to] want to take the first step – no one could force me"

Phase 1 – Stabilisation and Psychoeducation

4 - 6. Skills work - Grounding, symptom management, skills training

- Linking in with staff so they are able to support patients with grounding and skills techniques on the ward – both in individual sessions and ward based group sessions.
- Running multidisciplinary groups with both members of the OT department, nursing staff and healthcare assistants
- Understanding symptoms and emotional responses can help those who have experienced trauma to feel less powerless and out of control.
- Staff feedback: I've learnt different skills to support the patients on the wards including: "grounding skills – smells, touch, taste, coping skills – music, safe place imagery, whatever works for that individual"

Phase 1 – Stabilisation and Psychoeducation

7. Compassion Focused Therapy

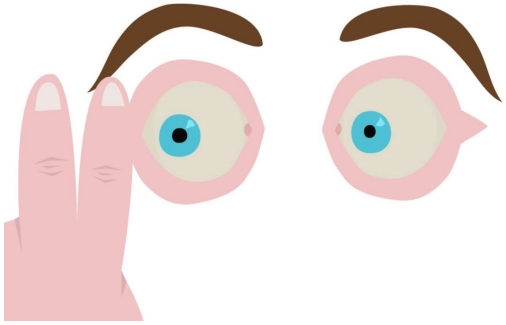
- CPTSD is likely to be shame-based, rather than fear-based as with PTSD (Lee and James, 2012). Importance of CFT first to try to increase compassionate ability.
- Both group and individual therapy sessions using a compassion focused therapy approach is particularly important for this population of patients who have a high level of shame and self-blame (includes on ward groups, off ward groups, and compassionate yoga).
- Ability to use these skills and develop a compassionate ability has been shown to be helpful in TF-CBT for the rescripts.

- Transition from phase one to phase two is dependent on the acquisition of skills rather than being determined by time in therapy (Courtois and Ford, 2009).
- Importance of skills being reinforced and supported by the ward staff is important for embedding these skills further.

Phase 2 - NICE Guideline Recommended Treatments (TF-CBT and EMDR)

- Evidence for Trauma focused CBT and EMDR being effective for CPTSD

- Both treatment options are offered at the Farndon Unit



Phase 2 - NICE Guideline Recommended Treatments (TF-CBT and EMDR)

Trauma-Focused CBT

- Involves imaginal exposure to traumatic memories and cognitive restructuring of the most distressing trauma related cognitions.
- Exposure to trauma-related cues provides the opportunity to update the traumatic memory

- *"I didn't recognise my thoughts and feelings [at first], no one had taught me how. I recognise now how I felt"*

Phase 2 - NICE Guideline Recommended Treatments (TF-CBT and EMDR)

Eye movement desensitisation and reprocessing (EMDR)

- EMDR is a psychotherapy first developed by Dr Francine Shapiro to reduce symptoms associated with PTSD. The therapist applies bilateral stimulation through alternative lateral eye movements, ear tones, or taps on the hands, while the client simultaneously accesses the stored traumatic memory (Shapiro 2001).

- *"EMDR wasn't for me [but] you've got to experience it for yourself, everyone's experience will be different"*

Staff's experience of Supporting Patients undergoing trauma therapy

- You have to understand that patients undergoing trauma therapy can be particularly difficult for them as they're bringing up traumatic memories, there can be a short term increase in trauma symptoms

- Care plans to support patients after trauma therapy can work well

- It can be difficult not knowing what they've done in the session but it's important to support them to use their grounding skills and coping skills, helping them to keep distracted if needed

Phase 3 - Reintegration, Reconnection and Recovery

- Has had less clinical and research attention than the other phases
- Phase three may be understood as the process of re-engaging with others, and with self
- It supports ability to engage compassionately with self and others, and (re)establish trust in self and others.
- It may involve reengage in friendships and intimate relationships, and in occupational activities that promote health and wellbeing, rather than re-enacting powerlessness (UKPTSD)

- At the Farndon Unit this phase is particularly important for individuals and patients at this stage often have greater links with the community engaging in social activities, courses, voluntary work.

Service user experience of undertaking trauma work

Prior to undertaking trauma therapy I was experiencing:

- *Repeated nightmares*
- *Always living in discomfort – always on the edge*
- *On high alert– small noises triggered me – especially at night*
- *High anxiety levels*
- *Wouldn't give eye contact to people I passed*
- *Relationships with staff weren't good – found it hard to trust them*

How I felt prior to starting trauma work:

- *It was hard, seemed like I was letting my guard down but I had trust in my therapist, building the therapeutic rapport helped to bring my guard down*

Service User Feedback

Motivation for engaging in trauma work:

- *"Wanted to help myself – I'd been carrying this burden, never knew how to share it before, never found that trustworthy person"*
- *"Wanted a better life and to understand why I am the way I am"*
- *"Talking to someone who I felt understood me"*

Have you noticed any differences as you're progressing with trauma work:

- *"Initially repeated dreams but eventually they went"*
- *"A load off my shoulders"*
- *"Now I make eye contact with the people I pass, I often see the same people and sometimes we say a quick hello"*

What would you say to a peer about trauma therapy?:

- *"You've got to experience it for yourself, everyone's experience will be different. Go and find a good psychologist and give it a go".*
- *"You have to find a psychologist you trust – got to be honest with yourself and your psychologist"*

Staff perspective of supporting patients who are undergoing trauma therapy

Experiences of supporting patients undertaking trauma therapy:

- Patients are more vulnerable post session and require extra support
- Increased risks of patients resorting to unhealthy coping mechanisms
- Nightmares/flashbacks

Have you learnt any skills to support the patients?

- Grounding skills – smells, touch, taste
- Coping skills – music, safe place imagery, whatever works for that individual

"I thought therapy didn't mean anything until I saw the effect it had on some of our patients – it's like they're different people now and we get to see them progress" – Healthcare Assistant

Staff perspective of supporting patients who are undergoing trauma therapy

Have you noticed any differences with a patients presentation after completing trauma therapy?

- “Patients seem generally calmer and more ‘at peace’”
- “Much less incidents of self-harm”
- “Better interactions with staff and peers”
- “More focused on their recovery”
- “Better head space”

“*It can be a multi-disciplinary approach as well as psychology, we have helped do some desensitization work with patients that have experienced trauma which makes it feel like their progress is a team effort.*” - Occupational Therapist

Staff perspective of supporting patients who are undergoing trauma therapy

Any surprises when supporting patients completing trauma therapy?

"An initial reluctance"

"The increased vulnerability"

"I didn't realise there were so many forms of trauma therapy"

"Big changes in behaviours" after completion of therapy

"Things get worse before they get better"

Staff perspective of supporting patients who are undergoing trauma therapy

Engaging in trauma work:

Advantages

- Patients learn to manage trauma
- Helps positively shape their future
- Helps them manage emotions positively
- Decrease in self-harm when complete
- More positive relationships
- Healthy coping strategies
- Focus on long term recovery and discharge

Disadvantages

- Brings up emotions from traumatic time, making it very real
- Short term increase of self-harm
- Short term emotional disruption
- Flashbacks and nightmares

Staff perspective of supporting patients who are undergoing trauma therapy

Anything further you think would help:

- *"More understanding about trauma work and the process would help us support patients more after sessions, and to have an additional set of skills to assist us with this may prevent any significant increases in risk behaviours*." – Staff Nurse

Special thanks to patients and staff who took part in reflecting on their experiences of trauma therapy

“It’s easy to judge. It’s more difficult to understand. Understanding requires compassion, patience, and a willingness to believe that good hearts sometimes choose poor methods. Through judging, we separate. Through understanding, we grow.” — Doe Zantamata

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