Trauma Informed Responses to Adolescents at Risk of Self-harm and/or Suicide

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Contents

Goals of the Training

- To provide the participants with guidelines for working with individuals who may be engage in self-harm and/or be suicidal
- To provide an overview of useful resources

(Please note: the material in these notes does not cover the routine, comprehensive assessment that should be undertaken of a young person when they are being cared for by an agency over an extended period)

Trauma Informed Care

Trauma informed Care has been described by Yeager and colleagues as:

"Care that is organised around a contemporary, comprehensive understanding of the impact of trauma that emphasises strengths, safety and focuses on skill development for individuals to rebuild a sense of personal control over their life…….

It is designed to be both preventative and rehabilitative in nature."

Yeager et al (2011).

This type of care is both a philosophy as well as a service delivery approach.

Trauma-informed care is based on the understanding that many clients have suffered traumatic experiences, and the provider is responsible for being sensitive to this fact, regardless of whether a person is being treated specifically for the trauma (Yeager et al, 2011) Therefore, workers should initially approach all of their clients as if they have a trauma history, regardless of the services for which the clients are being seen.

Trauma informed practice means asking everyone about the incidence of trauma in their lives and accepting that disclosure requires safety and often occurs over time.

Emphasis has shifted in services from “What is wrong with you?” to “What happened to you?’

Principles of Trauma Informed Care

Listed below are some important principles of Trauma Informed Care:

Physical and Emotional Safety

- safe welcoming environment
- consistency, predictability
- non shaming, non blaming, nonviolent
- privacy and confidentiality
- clear explanations about what is happening and why

Collaboration

- respect, information, connection, hope
- healing in the context of the interpersonal relationship
- flatten the hierarchy – no 'power over' experience
- explicit rights understood
- doing 'with' rather than 'to' or 'for'
- consumer is the ultimate expert

Trustworthiness

- trust earned and demonstrated over time
- consistency in practice
- maintaining appropriate professional boundaries
- transparent processes

•role clarity

•informed consent

Choice and Control

•maximise conscious choice and decision-making

•increase life options

•increase individual control and autonomy

•consumer pursues goals and dreams

•consumer chooses how contact occurs

(Hodas, 2006, NETI, 2005)

Principles that Guide Practice

- Awareness of the high prevalence of significant traumas in people's lives
- Awareness that the trauma may have lasting impact on the person
- Awareness that there may be multiple traumas affecting the person
- Understanding that the impact of the trauma may be outside of the person's awareness
- Awareness that the person may be affected in many, if not all, areas of their lives
- Understanding that screening for trauma should be routine
- Understanding and belief that may ***not*** have to work through/manage/explore all traumas and that you must go at the client's pace.
- Working with the client should build on their strengths while recognising that there may be times when the client feel helpless and without hope.

Possible Characteristics of Individuals who come from a Background of Abuse, Neglect and Trauma

Poor speech production and comprehension. Poor gross and fine motor skills. Low self esteem, depression, unstable mood. Controlling behaviour. Short attention span, memory difficulties, overactive behaviour. Poor self- help skills. Do not cope well with change. Aggressive and self- destructive behaviour and non-compliant behaviour. Unusual sexual behavior; Low empathy. Lack of cause and effect thinking, impulsive. Lack of trust. High anxiety, generally poor coping mechanisms. Anti-social behaviour, self- harm, substance abuse. Placing self at risk.

Supporting Individuals who are Acutely Emotionally Distressed

The Difference between Emotional Support and Counselling

Providing Emotional Support

Ensuring the person's physical safety; meeting the person's physical needs; asking questions; listening, empathising, showing concern; promoting realistic optimism; giving information; referring on.

Counselling

In addition to all the characteristics of emotional support, counselling usually involves: a discussion of the individual's history; the exploration of feelings and how one feeling connects with another; the linking of present feelings to past events; the linking of thoughts and feelings; the detailed discussion of the individual's perception of their present situation; the detailed discussion of significant events in their lives; the exploring of different courses of action and the examination of the pros and cons of those courses of action; suggestions from the person doing the counselling about courses of action that may assist the individual to improve their situation; giving advice.

What Helps the Individual who is Acutely Emotionally Distressed

To be physically safe. To have their physical needs met. To be emotionally safe. To be listened to. To be able to tell their story. To have their feelings validated. To have their responses and reactions accepted as normal. To gain a perspective on their situation. To be given information. To become emotionally connected with others. To be connected with resources. To be reminded of their strengths. To be given hope.

Working with the Individual who is Acutely Emotionally Distressed

Be clear about your role; the more bewildered, distressed and confused a person is-give less choice; remember that just being near someone who is very upset is likely to be re-assuring for them; be careful about being alone with the client -if you must be alone in a room, for example, make sure that the door is open; seek permission from the person before you offer support or ask any questions; empathise-to a point; be careful of asking lots of open ended questions-this may upset the client; the client may know what will help them. Asking them what they would like may the most effective and helpful thing to do; be careful about touch.

Guidelines for Working with Individuals Who May be Acutely Emotionally Distressed

1. Make your own safety your first priority. If doing home visits or site visits someone must know where you are and when you are due back. There must be a plan in place if you do not return. If concerned, do not go at all or, in some circumstances, go with a colleague. Park your car in such a way that you can get away quickly and always have your keys on you. If at any time you believe that you may be at risk, leave immediately.

2. Be clear about your role. If you are not employed as a counsellor do not take on a counselling role. It may be part of your role to provide brief emotional support.

3. Recognise that you do not have control over the actions of the other person and you cannot have control over past events or future events. Recognise that you can only do your best within your role.

4. Be careful about engaging in self disclosure. In some circumstances this may be helpful. However, in other situations it may confuse and/or distress the person you are offering support to.

5. If you talk about the concerns and distress of other people talk in very general terms and do not name anyone.

6. As long as you are safe, do not agree to keep a secret. Remember that a person's right to confidentiality is less important than their safety if they are at risk themselves and less important than other people's rights to safety if they are threatening others.

7. While it may be helpful to empathise and show interest in the other person and their concerns it is not necessarily useful to become engaged yourself in an emotional sense with their situation.

8. Learn to use language in a respectful way that suggests the possibility of change and the idea that the person may not always feel as they do. For example "I understand that things are very difficult for you right now……."

9. Recognise the importance of showing concern and the possible helpfulness of even brief contact with the person.

10. Develop an optimistic style and, while being respectful of the other person, convey realistic optimism in your manner and speech.

11. Be careful in your choice of words. Some people are happy to admit to being stressed but will not say that they are depressed.

12. Normalise the other person's situation and feelings while remaining respectful. For example "I know of other people who are in a similar situation as you and they feel the same way. I know that they have been helped by……."

13. Understand the beliefs, habits and behaviours that promote resilience and be prepared, if it is part of your role, to inform the other person about these things if you think it will help. Inform the person in very general terms and do not say "If you do this you will feel better……." or "You should do this……."

If it is part of your role you may say " I know other people who have been helped by …… . This may help you.' (nb: any referrals that you make must be to trusted, conventional services where there are high standards of service delivery that are regulated)

14. Pay lots of attention to how you discuss the individual's situation. Convey through your manner and choice of words the idea that we all have problems in living and that we all need additional support at times. If a person asks you if you think that they are crazy, weak, depressed, stupid etc consider saying "No, I do not. I think that you are the same as everyone else in the world. We all need additional help and support at times."

15. Recognise that some individuals may be more comfortable in thinking about assistance that they may receive as learning new skills but not happy about being given counselling.

16. Do not suggest that the person use alcohol to make themselves feel better.

17. If you are very concerned about the possibility that an individual may represent a risk to themselves or others ring the police and ask them to do a welfare check.

Engaging the Distressed Person

This material was originally written in regard to assisting people following a disaster eg: flood, fire, storm etc or following an industrial or car accident. However, it is applicable to working with anyone who may be acutely emotionally distressed.

- Do not ask about feelings.
- Say who you are and why you are there.
- Ask if there is anything the person needs or anything you can do for them. Give less choice to individuals who are very bewildered and confused. In the case of a child you may need to suggest what may help eg: to engage in an activity, to hold a comforting object.
- If you think it is helpful ask the person what happened.
- Try to find out what is upsetting or worrying the person ie their main source of concern.
- If you think it is helpful encourage the discussion of their recent experience, not their feelings.
- Reassure them about the support that is available to them now and will be available in the future.
- Find out what they need now.
- Offer assistance to go to a place of emotional and physical safety if needed.
- Arrange for follow up support.

(Adapted from Gordon, 2007)

Working With Children and Adolescents

- Consider sitting or crouching at a child's eye level.
- Consider helping children verbalise their feelings, concerns and questions; provide simple labels for common emotional reactions (e.g., mad, sad, scared, worried). Match the child's language to help you connect with them, and to help them to feel understood and to understand themselves. Do not increase their distress by using extreme words like "terrified" or "horrified."
- Match your language to the child's developmental level. Children twelve years and under typically have much less understanding of abstract concepts and metaphors compared to adults. Use direct and simple language as much as possible.
- Adolescents often appreciate having their feelings, concerns and questions addressed as adult-like, rather than child-like responses.
- Encourage the other adults caring for the young person to relate to them in the same way to help them provide appropriate emotional support to their children.
- Makes sure that the child/young person's routines are maintained outside of the school environment or modified in the child/young person's interests.
- The child/young person may need greater supervision and guidance after a distressing event, in particular for young people in relation to substance use and risky activities.

Adapted from: Psychological First Aid-Field Operations Guide. National Child Traumatic Stress Network. (see link at end of notes)

The Suicidal Client

Be clear about the limits of your role. If you are not employed as a counsellor do not take on a counselling role. Get the support of other staff to manage the situation. Remember that suicidal people are sometimes homicidal. Make your own safety your first priority. If it is safe to do so, do not leave the suicidal person alone even for the briefest period of time. Listen to what the person has to say. Where the person is hinting at suicide or self harm then consider asking them a direct question about their intent. Ask the person if

they are involved with other professionals eg psychiatrist, social worker, psychologist. Get the names of these people if you don't have them already. Consider suggesting that the person contacts these professionals. If the person is at immediate risk of harm ring the police and the ambulance service.

If the client is on the phone: find out as soon as possible where the person is physically and the phone number of where they are. Ask if there is anyone with them who may be of assistance. Recognise that anyone with the suicidal individual may be at risk of harm from the suicidal person. If the client leaves the phone and you think they may be suicidal do not hang up the phone if you want the call to be traced. Contact the professionals involved with the person if you think it is necessary.

Give information about other sources of support eg. Lifeline, the Suicide Help Line and the Kids Helpline. Ring the police and the ambulance service if you think that the person is at immediate risk.

Seek the support of other staff during and after the contact with the suicidal person as necessary. Recognise that these clients are likely to have an emotional impact upon you.

Useful Questions

The following questions may be helpful, depending on the age and developmental level of the person you are working with:

What has been helpful to you that got you through so far?

What are you doing to take care of yourself? (Get details, what, when, when, how and who)

What else has been helpful to you?

Who (and what) has been most helpful to you at this time?

What about them (and that) has been most helpful to you?

Have you been in a situation like this before?

- What did you do to get through it then?
- What was most helpful to you?
- Who helped you the most last time?
- How did you know that ……. would be helpful?

- What did …… do that was so helpful to you? What else?
- What would it take for …….. to help you again? What else?
- When you get that help again, what difference will it make for you this time?
- What do you think I can do that would be most helpful?

(Adapted from: Interviewing for Solutions by Peter de Jong and Insoo Kim Berg. Thomson Learning. 2002.)

Working with the Young Person who Engages in Self-harm

There are various types of self -harm including:

cutting and stabbing self; hanging and strangling; self-suffocation; jumping and throwing self from high places or in front of cars or trains; self-electrocution; self-battery; purposeful overuse of alcohol; purposeful overdosing on drugs; burning self; inhaling and sniffing dangerous substances; self -starving; stopping medication; shooting self to wound or kill; ingesting dangerous objects (eg batteries) and hair pulling; putting self at sexual risk. (N.B. Self-harm is often hidden)

(Adapted from: Stanford and Jones, 2009)

It is important to remember that if a young person engages in one sort of self-harm they are likely to engage in other forms of self-harm. Always ask about other sorts of self-harm if it is your role to do so.

Where a young person engages in self harm they may also involve themselves in different forms of risk taking. It is important to distinguish between what is normal, adolescent risk taking and risk taking of concern. Factors that will help you distinguish between normal risk taking and risk taking of concern are: the nature of the risk taking; frequency and; persistence over time.

Important Issues to Consider when Working with Young People

Be clear about your role

Be clear about professional boundaries: touch; self-disclosure; social and emotional boundaries

Be clear about confidentiality

Recognise the that you are not responsible for the outcome with the young person

Make sure that you are part of a team which may include a GP, psychologist, social worker, psychiatrist, paediatrician; speech pathologist, occupational therapist

Have a clear understanding of your model of change

Get supervision and support

Pay attention to your own self care

Areas to explore with the Young Person

(Please note: the material in these notes does not cover the routine, comprehensive assessment that should be undertaken of a young person when they are being cared for by an agency over a long period)

Listed below are areas that should be enquired about. Whether an individual worker asks about these areas will depend upon their role:

Physical health

Body Image

Gender identity

Sexuality

Friendships

Family relationships

Structure of their day and routines (sleeping, eating, going to bed)

Culture

Loss

Internet use-in particular sites that promote self-harm

Movies, music, art

Creativity

Tumblr, Facebook, Instagram, other social media

Exposure to self-harm and suicide

Abuse in the home and adverse life events

Learning difficulties/educational achievement

Bullying

Alcohol and drug use

Perfectionism

Impulsiveness

Contagion and beliefs around self-harm and suicide

Who, if anybody, provides them with parenting or parental supervision?

Enjoyable activities and people they enjoy being with

The process of self-harm and how to interrupt that process.

Research has found that restriction of access to means of suicide is particularly important.

Talking to Young People About Self Harm

If it is your role, consider asking the young person the following questions:

How long have you been……..?

How often do you…….?

Where on your body do you cut? (if enquiring about cutting)

What motivates you to……?

Have you tried to stop?

What happened when you tried to stop?

(Adapted from McVey-Noble et al, 2006)

Safety Plans

Stanley and Brown (2012) developed a brief intervention for individuals who may be suicidal and this has also been used with people who engage in self-harm.

The Safety Plan Intervention (SPI), where the person is suicidal, is best developed with the client following a comprehensive suicide risk assessment.

During the risk assessment, the worker should obtain an accurate account of the events that occurred before, during, and after the recent suicidal crisis.

The Safety Planning Intervention consists of a written, prioritized list of coping strategies and sources of support that clients can use to alleviate a suicidal crisis. The basic components of the SPI include (a) recognizing warning signs of an impending suicidal crisis; (b) employing internal coping strategies; (c) using social contacts and social settings as a means of distraction from suicidal thoughts; (d) using family members or friends to help resolve the crisis; (e) contacting mental health professionals or agencies; and (f) restricting access to lethal means.

SAFETY PLAN

Step 1: Warning signs:

1. _Thoughts and feeling worthless and hopeless_____
2. _Urges to self harm_____
3. _Wanting to be alone_____

Step 2: Internal coping strategies - Things I can do to distract myself without contacting anyone:

1. Listen to my favourite music_____

   Look at the (Name) App_____
2. Think about a good past experience_____

Step 3: Social situations and people that can help to distract me:

1. _Ring my best friend_____
2. _Go to the shopping centre_____
3. _Go to the local coffee shop_____

Step 4: People who I can ask for help:

1. Name_Mother_____ Phone __333-8666_____
2. Name_Former Carer _____Phone__333-7215_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name__Dr John Jones_____ Phone__333-7000_____

   Clinician Pager or Emergency Contact #__555 822-9999_____
2. Clinician Name_____ Phone_____

   Clinician Pager or Emergency Contact #_____
3. Local Hospital ED __City Hospital Center_____

   Local Hospital ED Address_222 Main St_____

   Local Hospital ED Phone ___333-9000_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK_____

Making the environment safe:

1. ____Keep knives in locked drawer where don't have the key_____
2. ____Don't keep alcohol in home_____
3. ____Only keep small amounts of medication_____

Resources

Useful Links re trauma informed care:

http://csp.cloud8.ionlinehosting.net/LinkClick.aspx?fileticket=6UAobvbsp7Y%3D&tabid=478

http://www.mhpod.gov.au/assets/sample_topics/combined/Trauma_and_Mental_Health/objective2/index.html

http://www.health.vic.gov.au/chiefpsychiatrist/creatingsafety/ntac/module6.pdf

http://www.sanctuaryweb.com/PDFs_new/ Bloom%20Organizational%20Stress%20as%20a%20Barrier%20to%20Trauma%20Chapter.pdf

A very useful fact sheet on self-harm can be found at the following link. It has information for the person who may be self-harming as well as for family and friends of someone who may be self-harming:

http://resources.beyondblue.org.au/prism/file?token=BL/1302

Advice for parents can be found at:

https://www.parentline.com.au/parenting-information/tip-sheets/self-harm.php

A very helpful overview of government approaches to self-harm can be found at:

https://www.orygen.org.au/Policy-Advocacy/Policy-Reports/Looking-the-Other-Way-Young-People-and-Self-Harm/Orygen-Looking-the-Other-Way-Young-People-and-Self

A very helpful manual from Headspace on managing self-harm can be found at:

http://www.psychology.org.au/Assets/Files/headspace-MCB.pdf

A very useful article on self- harm can be found at:

http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(11)61260-9.pdf

Above link is useful Lancet article re the persistence of self- harm into early adulthood.

A very useful blog from Michael Carr-Gregg on self-harm can be found at:

http://carrgregg.blogspot.com.au/2008/06/latest-self-harm-figures-from-australia.html

Information on Apps to use with young people can be found at:

http://www.ycentral.com.au/wp-content/uploads/2014/11/Psychologist-Interview-Dr-Michael-Carr-Gregg-on-Great-Tools-to-Use-with-Young-People.pdf

A useful video re: self-harm from Headspace can be found at:

https://www.youtube.com/watch?feature=player_embedded&v=OY5akjDzm18

Useful links re Psychological First Aid

The first of the links below gives detailed information about Psychological First Aid. The second is a brief pamphlet about Psychological First Aid.

https://www.medicalreservecorps.gov/file/mrc_resources/mrc_pfa.doc

http://www.psychology.org.au/Assets/Files/Red-Cross-Psychological-First-Aid-Book.pdf

References

Bloom, S. L. (2010). Organizational Stress as a Barrier to Trauma-Â•Informed Service Delivery. In Becker, M. and Levin, B. (Eds). A Public Health Perspective of Women's Mental Health, New York: Springer pp.295-311. Retrieved from

Chandler, G. (2008). From traditional inpatient to trauma-informed treatment: transferring control from staff to patient. J Am Psychiatr Nurses Assoc, 14(5), 363-371.

Elliott, D.E., Bjelajac, P., Fallot, R.D., Markoff, L.S., Reed, B.G. (2005). Trauma-informed or trauma-denied: principles and implementation of trauma-informed services for women. Journal of Community Psychology, 33(4), 461-477. DOI: 10.1002/jcop.20063

Gordon, R. Psychological First Aid. DHS Victoria publication. 2007.

Hawton, K., ; Saunders, K E A; O'Connor, R. C. The Lancet; London, 379.9834 (Jun 23-Jun 29, 2012): 2373-82.

Hodas, G. (2006). Responding to childhood trauma. The promise and practice of informed care. Pennsylvania Office of Mental Health and Substance Abuse Service.

Huckshorn, K., Lebel, J. L. (2013). Trauma-informed care. In Yeager, K., Cutler, D., Svendsen, D., & Sills, G. (Eds.) Modern community mental health: An interdisciplinary approach. (pp. 62-83) Oxford, England: Oxford University Press.

Jennings, A., Ralph, R.O. (1997). In their own words. Trauma survivors and professionals. They trust, tell what hurts, what helps and what is needed for trauma services. Trauma Advisory Groups Report. The Department of Mental Health, Mental Retardation and Substance Abuse Services, Maine.

Hodas, G.R. (2006). Responding to childhood trauma: The promise and practice of trauma informed care. Pennsylvania Office of Mental Health and Substance Abuse Services.

McVey-Noble, M., Hkemlani-Patel, S and Neziroglu, F. When Your Child is Cutting-A Parent's Guide to Helping Children Overcome Self-Injury. New Harbinger. 2006.

National Executive Training Institute (NETI). (2005). Training curriculum for reduction of seclusion and restraint. Draft curriculum manual. Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD), National Technical Assistance Center for State Mental Health Planning (NTAC).

Read, J., Hammersley, P., Rudegeair, T. (2007). Why, when and how to ask about childhood abuse. Advances in Psychiatric Treatment, 13,101-110. DOI: 10.1192/apt.bp.106.002840

Robins, C.S., Sauvageot, J.A., Cusack, K.J., Suffoletta-Maierle, S., Frueh, B.C. (2005). Consumers' Perceptions of Negative Experiences and "Sanctuary Harm" in Psychiatric Settings. Psychiatric Services, 56(9), 1134-1138.

Stanford, S. and Jones, M. How much detail needs to be elucidated in self-harm research. Journal of Youth Adolescence. (2010), 39, 505-513.

Stanley, B. and Brown, K. Safety Planning Intervention: a brief intervention to mitigate suicide risk. Cognitive and Behavioural Practice, 19,2012, 256-264.

Steele, W. and Malchiodi, C. Trauma Informed Practices with Children and Adolescents. Taylor and Francis. 2011.

Yeager et al. Modern Community Mental Health: an interdisciplinary approach. Oxford University Press. 2013.