Health Education England

12:00pm – 12:45pm – Keynote Speakers

Dr Catherine Parker

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&

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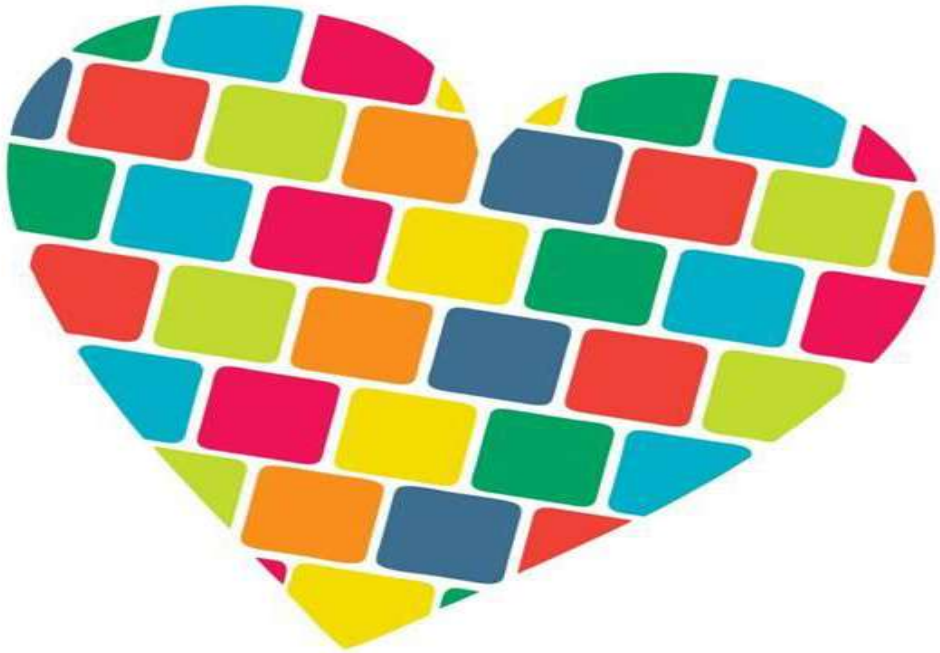
Physical health and trauma approaches to manage chronic conditions

Cumbria Partnership NHS
NHS Foundation Trust

Trauma and Physical Health



Happier | **Healthier** | Hopeful

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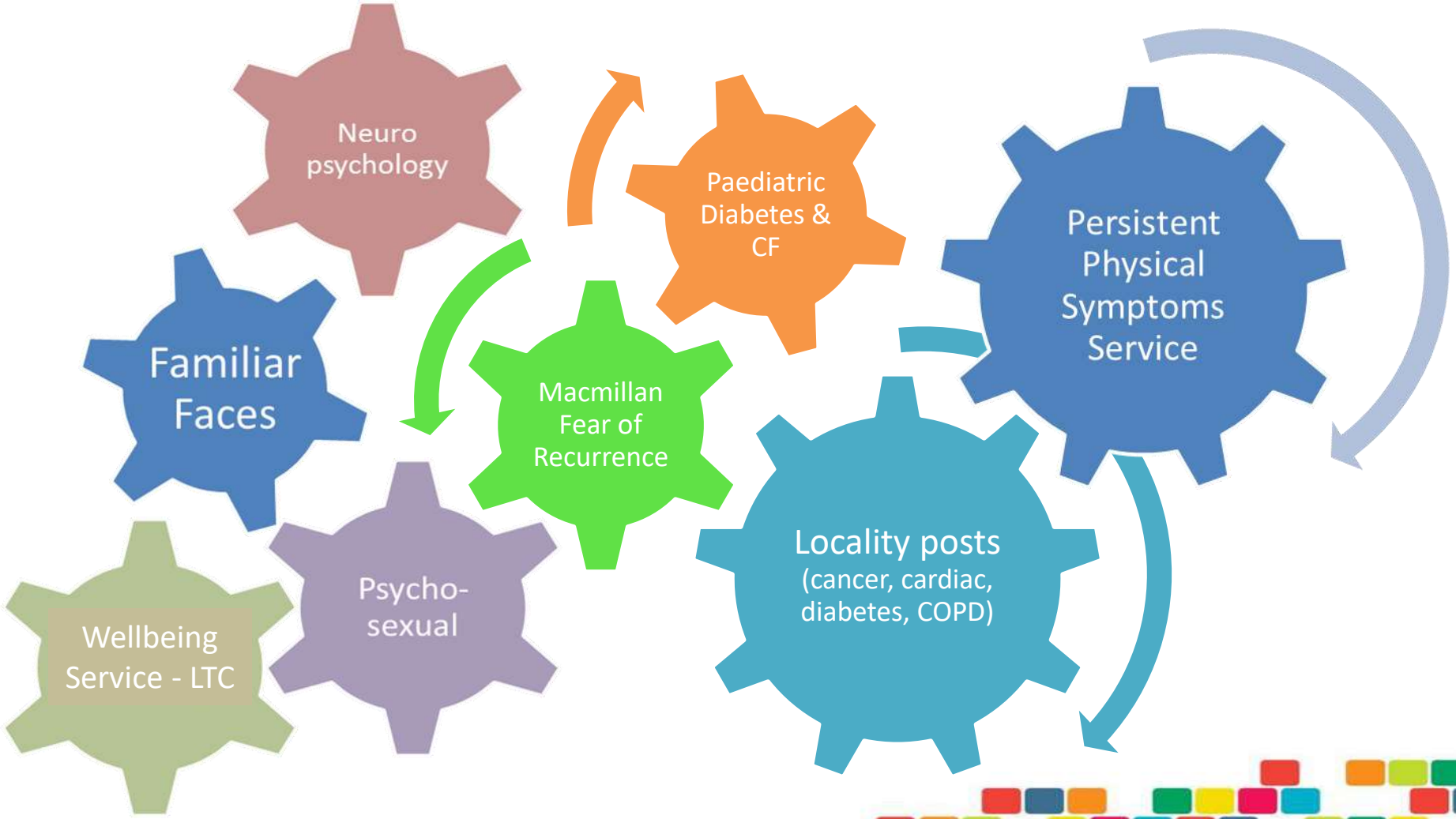
Physical Health and Rehabilitation Psychology Services in Cumbria



Health Psychology

- Addressing psychological factors associated with physical health conditions
  - Adjustment and coping
  - Engagement in treatment and adherence
  - Reducing distress
  - Helping decision making
  - Lifestyle changes
  - Medically unexplained symptoms
  - Living well with persistent physical symptoms

Familiar Faces

Addressing the needs of **frequent attenders***

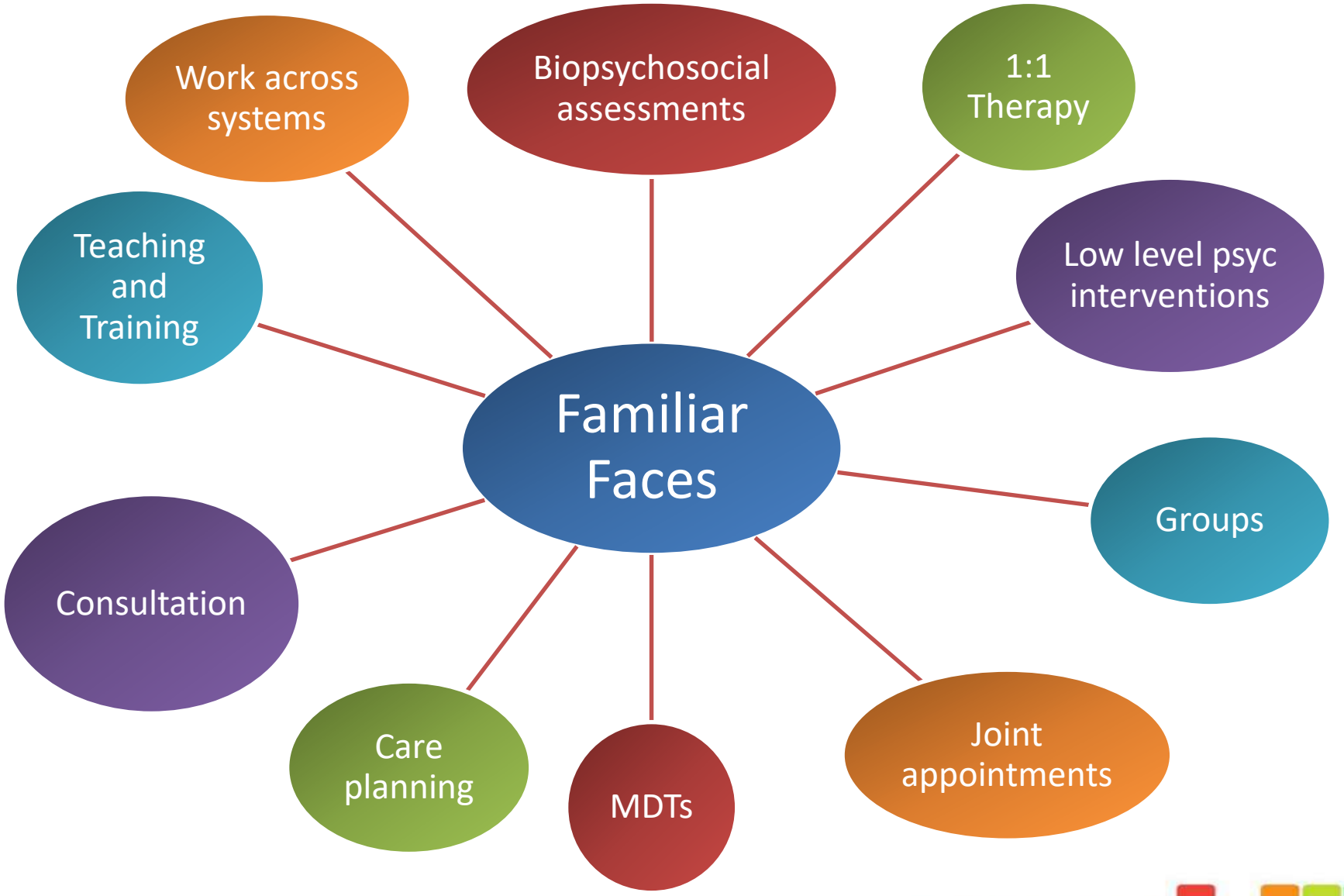
(GP, Out of hours, A & E, outpatients, hospital admissions)

Enabling people with complex physical, social and psychological needs to make significant positive changes in their wellbeing and health management

*Defined as the top 1% of attenders in primary and secondary care

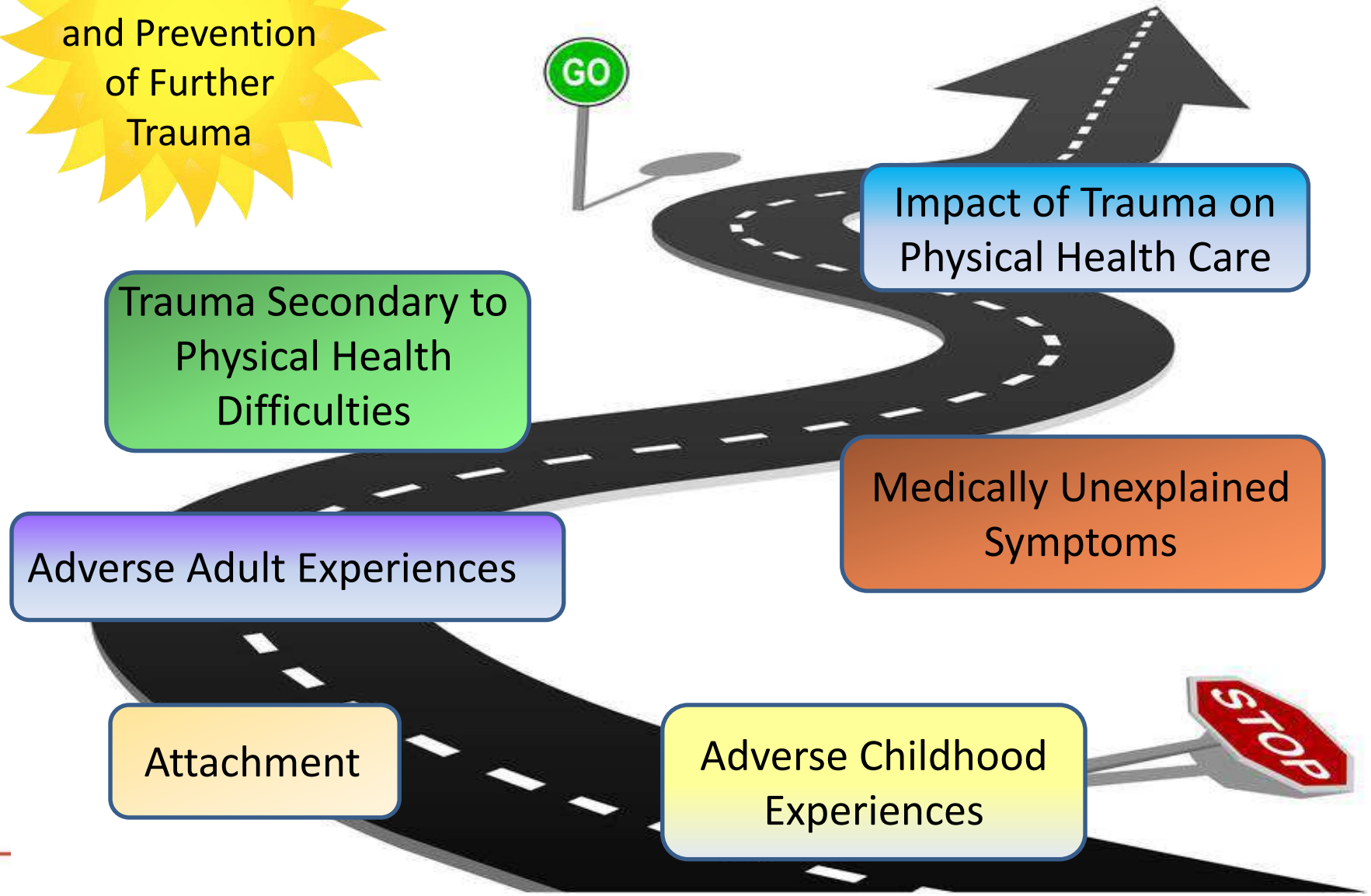
Familiar Faces

- Clinical Psychologists and Living Well Coaches (LWCs)
- Embedded within ICCs throughout North Cumbria
- Assertive outreach approach to engaging clients into the pathway
- Formulation takes into account each aspect of the biopsychosocial model


Work across systems
Biopsychosocial assessments
1:1 Therapy
Teaching and Training
Low level psyc interventions
Familiar Faces
Groups
Consultation
Care planning
MDTs
Joint appointments

Trauma and Physical Health

Trauma Informed Care and Prevention of Further Trauma



Impact of Trauma on Physical Health Care

Trauma Secondary to Physical Health Difficulties

Medically Unexplained Symptoms

Adverse Adult Experiences

Attachment

Adverse Childhood Experiences

Trauma
A broad definition

- A traumatic event or situation creates psychological trauma when it overwhelms the individual's ability to cope or integrate the emotions involved with that experience

- The individual may feel emotionally, cognitively, and physically overwhelmed.

Big “T” Trauma

- Big “T” trauma
  - A person is exposed to an immediate threat to one’s life or loved one such as a car accident, or physical or sexual assault

- Common symptoms include:
  - Relieving aspects of what happened
  - Alertness or feeling on edge
  - Avoiding feelings, memories or places
  - Difficult beliefs or feelings

Small “t” Trauma

- Small “t” trauma/Complex PTSD
  - Defined not because they are less traumatic but because they are more ubiquitous.
  - A person is exposed to chronic or repetitive experiences such as child abuse, neglect, combat, urban violence, domestic violence, and enduring deprivation.
- You are more likely to develop complex PTSD if:
  - you experienced trauma at an early age
  - the trauma lasted for a long time
  - escape or rescue were unlikely or impossible
  - you have experienced multiple traumas
  - you were harmed by someone close to you.

Complex PTSD

- In C-PTSD a person can experience some additional symptoms, such as:
  - difficulty controlling emotions
  - feeling very hostile or distrustful towards the world
  - constant feelings of emptiness or hopelessness
  - feeling as if you are permanently damaged or worthless
  - feeling as if you are completely different to other people
  - feeling like nobody can understand what happened to you
  - avoiding friendships and relationships, or finding them very difficult
  - often experiencing dissociative symptoms such as depersonalisation or derealisation
  - regular suicidal feelings

Impact of Trauma on Physical Health

- Adverse Childhood Experiences (ACEs) & Physical Health (Felitti et al, 1998)
  - Study found as the number of ACEs increased, so did the risk of experiencing a range of health conditions in adulthood including diabetes, heart disease, and COPD.
  - This study has been replicated in England and Wales with similar results

- Hypothesised mechanisms of action of childhood adversity include:
  - Neurobiological
  - Psychoimmunobiological
  - Epigenetic
  - Learning theory
  - **Attachment theory**
  - **Toxic stress**

The ACE Pyramid

Attachment Theory and Health

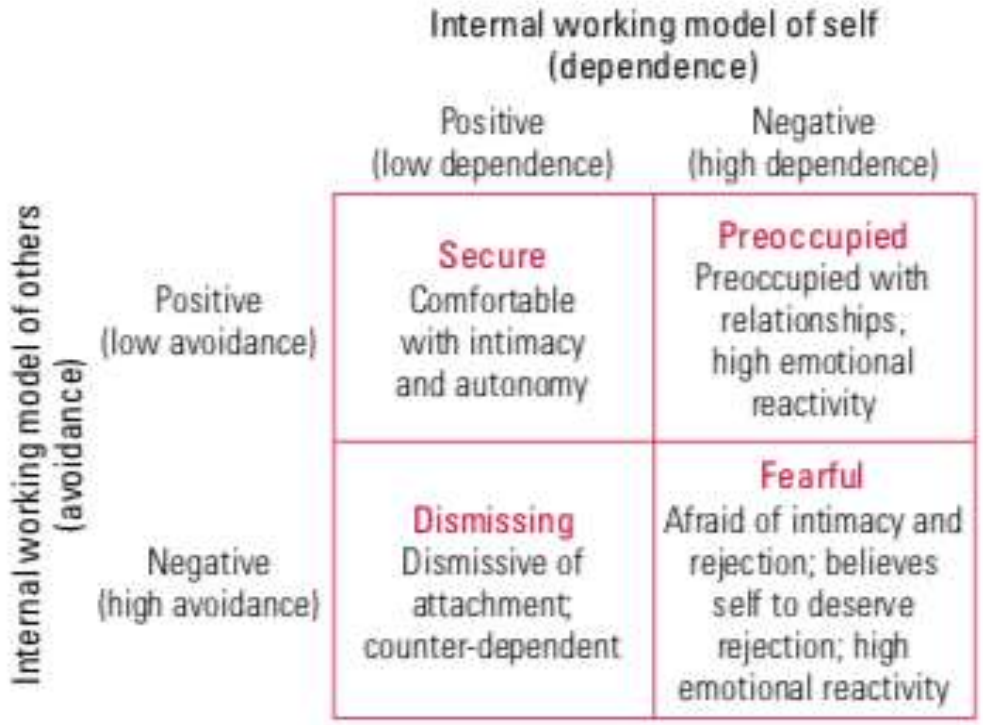
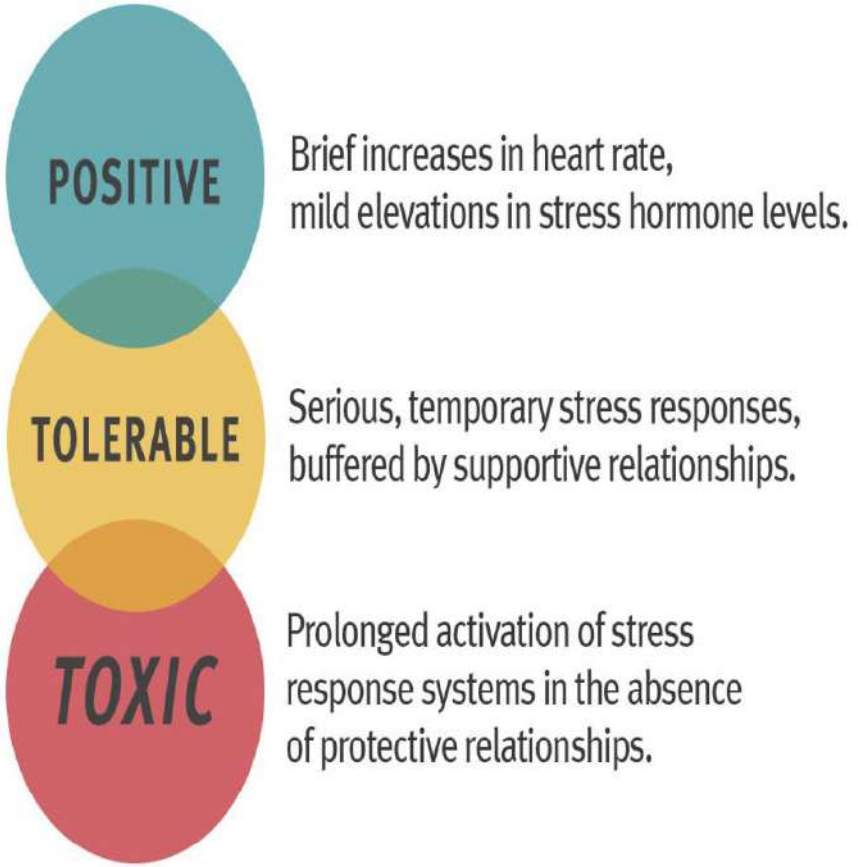


FIG 1 The four-category model of adult attachment (from Ma 2006, after Bartholomew 1991).

TABLE 1 **How attachment style affects care-eliciting behaviour and relationships with professional caregivers**

Attachment pattern	Attitude to care seeking	Attitude to caregivers
Secure	Positive approach to seeking help	Trusting, confident, collaborative, valuing of help
Dismissing	Reluctant to seek help or appear dependent	Suspicious, guarded, keen to keep interactions brief. May not adhere to treatment and may fail to keep appointments
Ambivalent	Seeks help when anxious, but then withdraws	Initially positive but then may complain and/or be hostile. May not adhere to treatment
Anxious/fearful	Seeks help, but then withdraws	Engages then withdraws. Is not reassured by caregiver. May fail to keep appointments
Disorganised attachment (mixture of dismissing and fearful)	Avoidant and non-engaging	May be frightened by caregivers and treatment
Derogating of attachment (extreme dismissing stance)	Avoidant; hostile to idea of being dependent	May be actively hostile to care-givers, derogatory about treatment

TOXIC STRESS



Impact of Toxic Stress

- Learning to deal with stress is an important part of healthy development
- However, when the stress response is activated and set permanently on high alert – Stress becomes TOXIC
- An important buffer to toxic stress is a responsive parental figure
- In the absence of a responsive adult the stress response system can become activated even when there is no apparent physical harm
- Constant activation of the stress response overloads developing systems with serious life long consequences, for example;
  - In the areas of the brain dedicated to learning and reasoning the neural connections are weaker and fewer in number

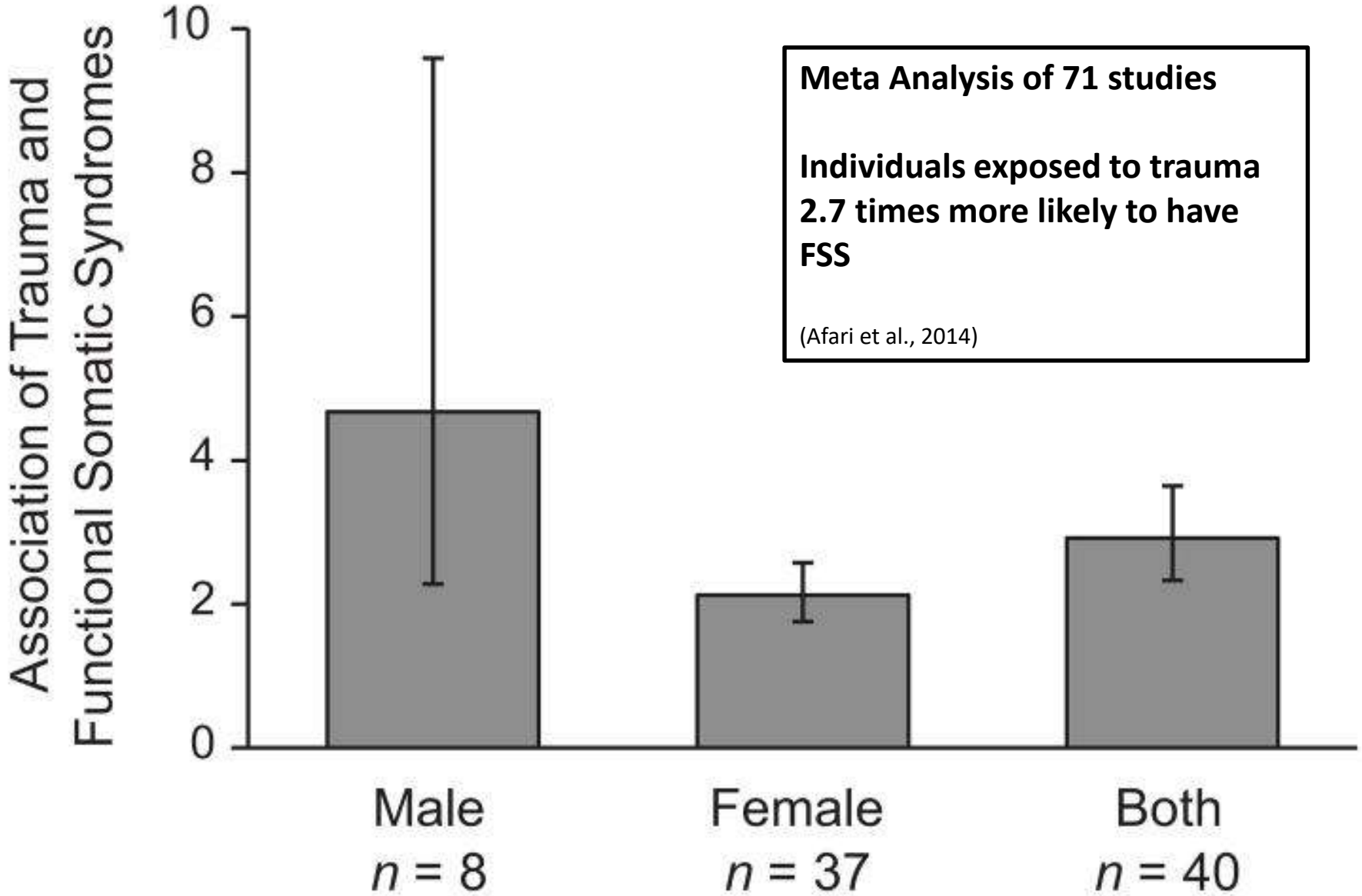
Medically Unexplained Symptoms

- Physical symptoms persisting for more than several weeks and for which adequate medical examination has not revealed a condition that adequately explains the symptoms

- MUS is a **working hypothesis**. Change in symptoms could be reason to revise the hypothesis.

Medically Unexplained Symptoms

- Chronic fatigue syndrome
- Fibromyalgia
- Irritable bowel syndrome
- Post concussion syndrome
- Non-cardiac chest pain
- Temporomandibular joint
- Multiple chemical sensitivity



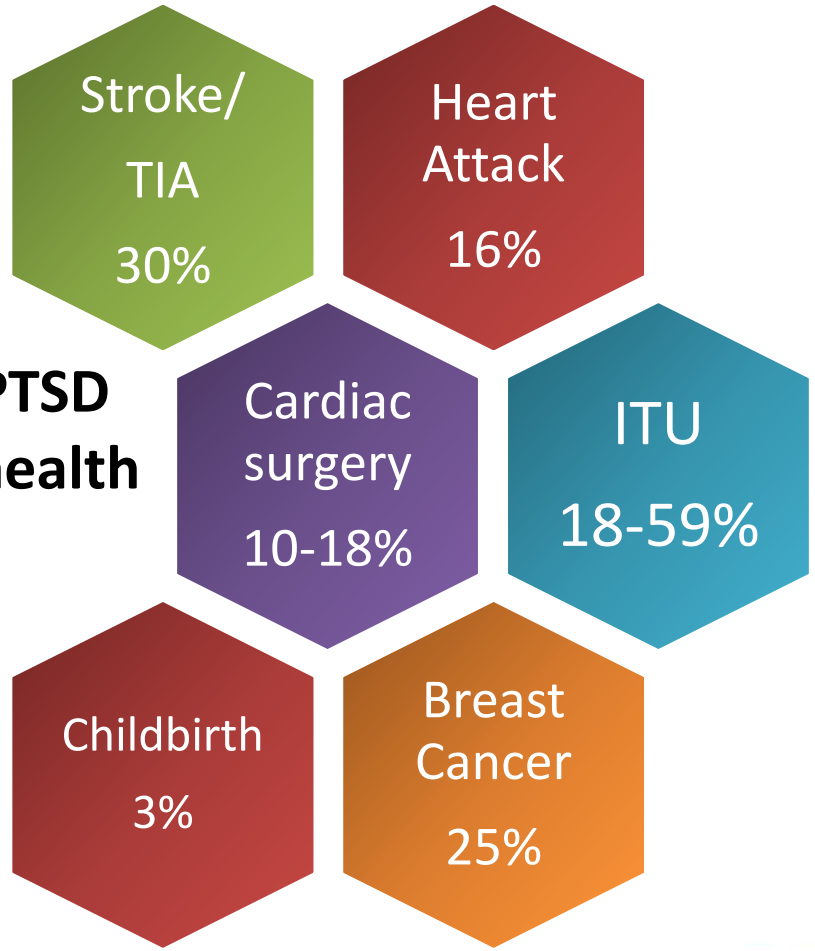
Meta Analysis of 71 studies

Individuals exposed to trauma 2.7 times more likely to have FSS

(Afari et al., 2014)

Trauma Secondary to Physical Health Events

Prevalence of PTSD after physical health events



Impact of Trauma

- Increased levels of distress associated with disease
- Fear of recurrence
- Difficulties adjusting to changes in physical health
- Impact of trauma on engagement with services/health care usage

Trauma and Health Care

- Engagement with services
- Adherence to treatment plan
- Self-management
- Attachment and care-seeking behaviours
- Increased health care usage
  - Increased GP attendances, hospital stays, length of stay

Case Conceptualisation

- Formulating physical health presentation/response to physical health condition in context of past events/traumas

- Adaptive information processing model
  - Memories are stored in memory networks
  - Memory networks form the basis for our perceptions, attitudes and behaviours
  - New experiences are assimilated into memory networks
  - Trauma = ‘unprocessed’ or dysfunctionally stored information

Trauma Interventions

- NICE guidelines CG26: Post-traumatic stress disorder
- UK Psychological Trauma Society (2017): Complex PTSD

- **Phase one**: stabilisation (establishing safety, symptom management, improving emotion regulation and addressing current stressors)

- **Phase two**: trauma processing (focused processing of traumatic memories)
  - Grounding techniques/self-regulation
  - EMDR
    - Resource installation
    - Trauma processing
  - Trauma Focused-CBT

- **Phase three**: reintegration (re-establishing social and cultural connection and addressing personal quality of life).

- Working with systems supporting the client

Other Interventions

- Skills building
- Acceptance and commitment therapy
- Compassion focused therapy
- Cognitive behavioural approaches to managing physical health conditions

Trauma Informed Practice

- Offer person a different relationship to that of the trauma experience. One that enables the client to:
  - Feel safe
  - Empowered
  - Have choice and control
- Work together with the client
- Offer choice over the gender of the person offering support
- Empowering people to have control and take an active role in what happens to them
- Being clear about what will happen, doing what you say you will do, when you said you would do it
- Ensure we are all safe and connected

Trauma Informed Practice

Safety	Choice	Collaboration	Trustworthiness	Empowerment
				
Definitions				
Ensuring physical and emotional safety	Individual has choice and control	Making decisions with the individual and sharing power	Task clarity, consistency, and Interpersonal Boundaries	Prioritizing empowerment and skill building
Principles in Practice				
Common areas are welcoming and privacy is respected	Individuals are provided a clear and appropriate message about their rights and responsibilities	Individuals are provided a significant role in planning and evaluating services	Respectful and professional boundaries are maintained	Providing an atmosphere that allows individuals to feel validated and affirmed with each and every contact at the agency

DIRECT WORK

Mind/Body Link. Functional Neurological Disorder (FND)

INDIRECT/INFLUENCING

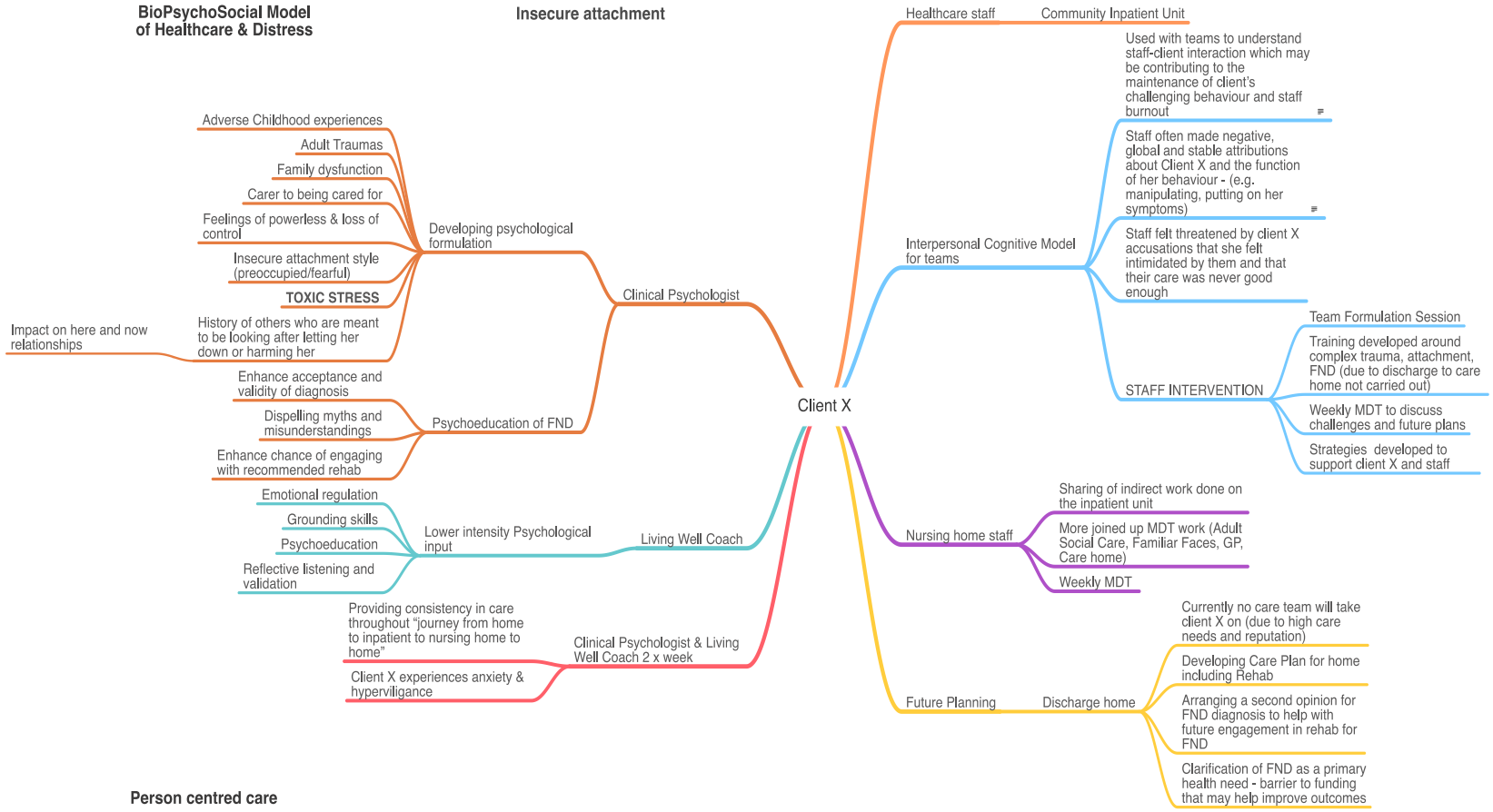
Adverse childhood experiences - direct link to adult physical/mental problems

TOXIC STRESS

Consistency

BioPsychoSocial Model of Healthcare & Distress

Insecure attachment



Person centred care

Collaborative working between client and staff

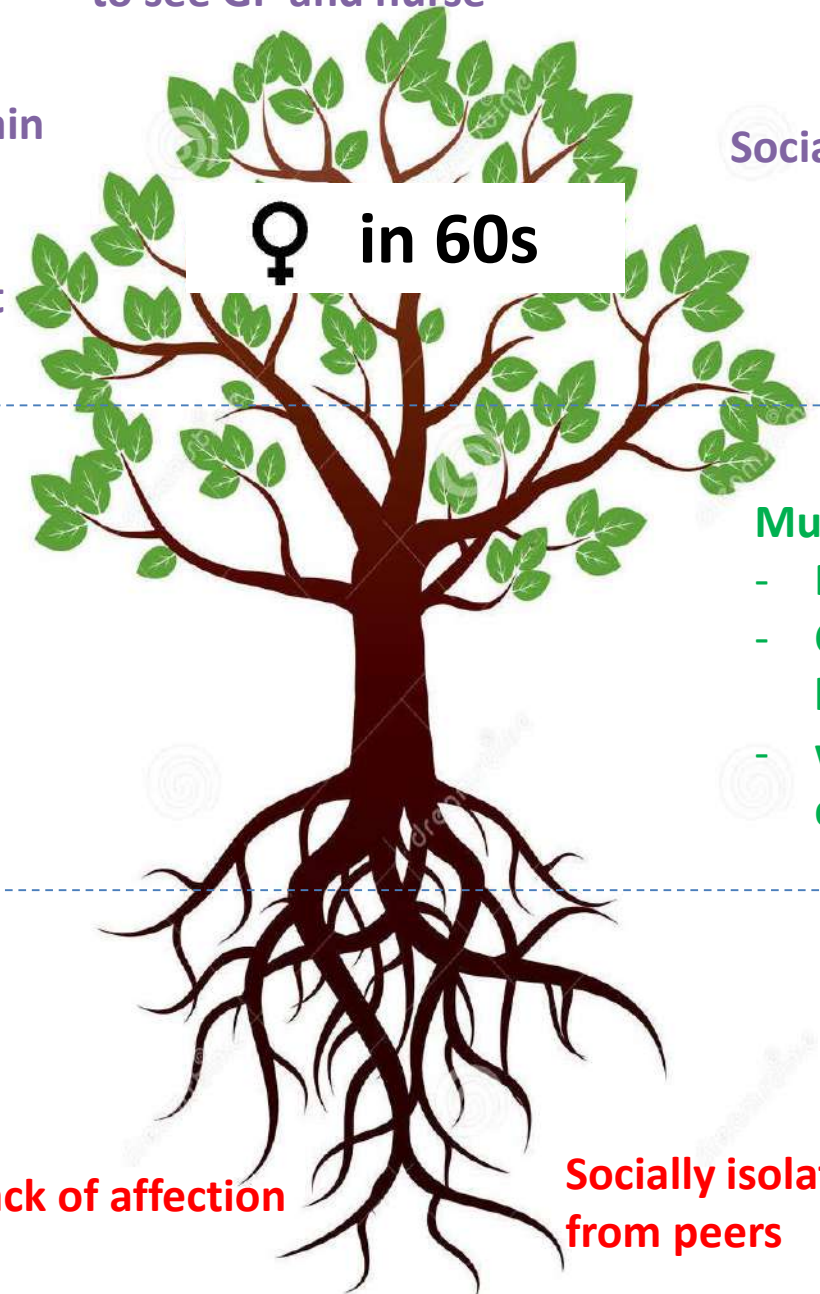
Compassionate care

Regular attendances to see GP and nurse

Anxiety about symptoms; fear of catastrophic cause.

Multiple physical symptoms
- Back and neck pain
- Sore mouth
- Abdominal pains/discomfort

Social withdrawal



Generalised anxiety

Swallowing problems

Supporting son with severe mental health difficulties

Multiple bereavement
- Father
- Cancer "found too late"
- witnessing brother's death by choking

Emotional and sexual abuse in first marriage

Oldest of 6 children – parental responsibility at a young age

Witnessed domestic abuse

Alcoholic father

Lack of affection

Socially isolated from peers

Physical abuse

Treatment

- Phase 1: Stabilisation and Resource Building
  - Psychoeducation about anxiety
  - Psychoeducation MUS
  - Mindfulness
  - Calm place
  - Visualisation of required skills to cope
- Phase 2: Processing the Trauma
  - EMDR
- Phase 3: Reintegration and reconnection

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