
Chapter 5 – Trauma informed care & practice

The pros and cons of implementing trauma informed care in Danish psychiatry

Paper

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Keywords: Mental health, nursing, trauma, trauma informed care

Introduction

Trauma informed care could be defined as: A strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment

Background

Principals of Trauma Informed Care (TIC) are implemented at many mental health hospitals across the US. In Denmark there are no such principals implemented. That might be because patients and staff don't experience trauma to the same extent as in the US. The OECDs social indicators ranked Denmark in top with a score on safety at 85% (safe walking alone at night), and life satisfaction on 7.5 on a scale from 0 to 10. The US is ranked lower, with a safety score on 74%, and life satisfaction on 6.9 (2).

Objectives

This study explores to what extent patients and staff in Denmark, has been exposed to traumatic experiences earlier in life, compared to patients and staff in US.

Methods

A cross sectional survey on trauma experiences among patients admitted to a psychiatric ward and staff-members working at two psychiatric wards (one forensic and one dual-diagnostic), using the Brief Trauma Questionnaire (BTQ) (3) were conducted. The BTQ was translated to Danish, back translated to English, compared and revised accordantly, by the two authors. The questionnaire was distributed electronically, using Enalyzer (4), and handled anonymously, so that the researchers were blinded to who the respondent were. All analyses were performed using IBM SPSS Statistics for Windows, Version 22.0 (Released 2013; IBM Corp., Armonk, NY).

Results

The sex distribution of the respondent showed 27% were men, the average age was between 41 and 50 years, the education was distributed with 44% nurses aids, 31% nurses, 12% psychologists/psychiatrists, and 13% others, and the response rate was 69.4% (respondents, N=309).

Table 1. Distribution of traumatic life events among staff in two mental health wards in Denmark

Traumatic life events (N=309)	%	(n)
1. Experiencing war (life in danger/seriously injured)	2	(5)
2. Serious accident (life in danger/seriously injured)	23	(70)
3. Natural or technological disaster (life in danger/seriously injured)	6	(17)
4. Life threatening disease (life in danger/seriously injured)	7	(23)
5. Childhood trauma (physically punished or beaten - life in danger/seriously injured)	8	(26)
6. Childhood trauma (attacked, beaten or bullied - life in danger/seriously injured)	22	(68)
7. Unwanted sexual contact (life in danger/seriously injured)	4	(13)
8. Seriously injured (seriously injured)	7	(20)
9. Close persons death after a violent incident	20	(62)
10. Witnessed other person seriously injured or killed	25	(76)
At least one incident	63.7	(197)
At least two incidents	34.3	(106)
At least three incidents	16.8	(52)
At least four incidents	6.1	(19)
At least five incidents	1.6	(5)
Six incidents	0.3	(1)

Note. Descriptive statistics of traumatic life events. N = number of all respondents. % = percent of respondents in the group. n = number of respondents in the group.

Table 1, the most common traumatic life event was “Witnessed other person seriously injured or killed” 25%, the next was “Serious accident (life in danger/seriously injured)” 23%, followed by “Childhood trauma (attacked, beaten or bullied - life in danger/seriously injured)” 22%. Regarding the number of traumatic life events, 64% of the staff members had experienced at least one traumatic life event, 34% at least two events, 17% at least three events, 6% at least four events, 2% at least five events, and last 0.3% equal to one person six events, out of ten possible events.

Table 2. Associations between traumatic life events and background variables

Background variables	B	95% CIs of B	p
Ward (forensic ward vs. dual-diagnostic ward)	0.10	[-0.24, 0.45]	.55
Sex (male vs. female)	-0.23	[-0.59, 0.14]	.23
Age (five, 10 years groups)	-0.07	[-0.20, 0.07]	.31
Education (nursing aids/nurses vs. psychologists/psychiatrists)	-0.61	[-1.08, -0.15]	.01

Note. The parameters (B) were estimated using a linear regression, and all background variables were analysed together. The parameters should be interpreted as, e.g. education; there is a difference between the two groups of 0.6 traumatic life events in average.

Table 2, the only background variable significantly associated with number of traumatic life events was education. We found higher educated staff (psychologists and psychiatrists), in average had experienced fewer traumatic life events ($B = -0.61, p = .01$).

Preliminary results from the survey where the respondents were patients with a dual-diagnostic diagnose will be presented at the congress.

Conclusions

Quit a large amount of the staff had experienced traumatic life events, and a few had experienced several.

Conclusions from the patient survey will be presented at the congress.

Discussion

The use of BTQ to collect data on traumatic life events was chosen because it is brief, and easily understood by respondents. Schnurr (5), found Kappa coefficients for the presence of trauma that met DSM criterion A1 were above .70 (range .74-1.00) for all events, except for disease (.69) and “other persons seriously injured or killed” (.60). So the BTQ would find trauma in a good or almost perfect way.

Using an electronical system (Eanalyzer) to collect the questionnaires, which was able to hide the identity of the respondents to the researchers, could be one of the reasons why so many answered the very private and sensitive questions, and thereby strengthen the representativeness of the study. The response rate of 69.4% would in many cases be described as acceptable (6), and the likelihood of response bias rather low.

The amount of staff that experienced traumatic life events was not very different from earlier findings of population samples in the US, Kessler (7) found 56%, and Breslau (8) found 61% had experienced at least one traumatic life event. Also, the level of education has been found earlier to be associated with the number of traumatic life events (9). So even though we score higher on safety, and life satisfaction, on the OECDs social indicators, this seems not to be connected to experiencing lesser traumatic life events.

It seems that we can (before we know how many traumatic life events the patients experience) deduce, that it is not because the staffs in Denmark experiences fewer traumatic life events, that we have not implemented principals of TIC. And because the amount of traumatic life events is as high as in the US, it is an area we as staff (and patients) probably should be more interested in, and paying more attention to.

Acknowledgements

We would like to thank the staff and patients at Mental Health Centre Sct. Hans, for trustingly answer the questionnaire about trauma-experiences.

References

1. Hopper EK, Bassuk EL, Olivet J. Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal* 2010;3(2):80-100.
2. *Better Life Index*. OECD.Stat . 2016. OECD. 17-7-2017. Ref Type: Online Source
3. Schnurr P, Vielhauer M, Weathers F, Findler M. *The brief trauma questionnaire*. White River Junction, VT: National Center for PTSD. 1999.
4. *Eanalyzer Survey Solution* [computer program]. København: Eanalyzer A/S; 2010.
5. Schnurr PP, Spiro A, Vielhauer MJ, Findler MN, Hamblen JL. Trauma in the lives of older men: Findings from the Normative Aging Study. *Journal of Clinical Geropsychology* 2002;8(3):175-87.

6. Draugalis JR, Coons SJ, Plaza CM. Best practices for survey research reports: a synopsis for authors and reviewers. *American journal of pharmaceutical education* 2008;72(1):11.
7. Kessler RC, Sonnega A, Bromet E, Hughes M, Nelson CB. Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of general psychiatry* 1995;52(12):1048-60.
8. Breslau N, Chilcoat HD, Kessler RC, Davis GC. Previous exposure to trauma and PTSD effects of subsequent trauma: results from the Detroit Area Survey of Trauma. *American journal of Psychiatry* 1999;156(6):902-7.
9. Breslau N, Davis GC, Andreski P, Peterson E. Traumatic events and posttraumatic stress disorder in an urban population of young adults. *Archives of general psychiatry* 1991;48(3):216-22.

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