TRAUMA INFORMED CARE & YOUTH VIOLENCE

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INTRODUCTION

FRAMEWORK FOR THIS TRAINING

- Urgent need for TIC.
- Provision of trauma informed care and restraint reduction are developmental processes.
- Requires time, planning, and persistence.
- No training or TA can circumvent this process.
- Commitment & leadership by all stakeholders needed, with youth and family participation.
INTRODUCTION

THREE MAIN THEMES TO BE EXPLORED

● “Childhood trauma constitutes a public health crisis, with serious consequences.”

● “Trauma informed care (TIC) is an organizing principle of care, which can promote prosocial adaptation and decrease community violence.”

● “TIC can be implemented in multiple systems and settings.”
INTRODUCTION

STRUCTURE OF PRESENTATION

- Introductory concepts
- Three themes:
  - TIC as public health crisis
  - Concept of TIC
  - Cross-system implementation
- Conclusions & Discussion
INTRODUCTORY CONCEPTS

AREAS FOR REVIEW

- Overview and underlying assumptions.
- Definition of trauma.
- Trauma typology (types of trauma)
- Determinants of an individual’s response to trauma
- Primary focus – maltreatment and loss
INTRODUCTORY CONCEPTS

WHAT WE KNOW ABOUT CHILDHOOD TRAUMA

- There are many potential types of trauma.
- Single events disrupt the life of child and family, but often resolve without serious long-term damage.
- Severe, chronic, and/or recurring trauma can have serious, long-term consequences.
- These consequences can affect every aspect of a child’s functioning, including mental and physical health, values & beliefs, learning, and behavior.
INTRODUCTORY CONCEPTS

UNDERLYING ASSUMPTIONS

- Significant common ground among systems for how to respond to youth with complex needs.
- TIC maximizes youth’s chance of resilience, recovery, and constructive community living.
- TIC not invalidate individual responsibility and accountability, incorporates community safety
- Relevance of TIC not limited to just individuals with SED – applicable to all youth, and to communities.
INTRODUCTORY CONCEPTS

CHARACTERISTICS OF TRAUMA

- Traumatic event (per DSM IV) involves experiencing, witnessing, or being confronted by event or events that involved “actual or threatened death or serious injury, or a threat to the integrity of self or others.”

- The individual’s response involved “intense fear, helplessness, or horror” (with children, may have disorganized or agitated behavior).

- Only 2 trauma-related diagnoses: Acute Stress Disorder, and Posttraumatic Stress Disorder (re-experiencing, avoidance/numbering, hyperarousal).
INTRODUCTORY CONCEPTS

TYPES OF TRAUMA

- Neglect, and abuse – physical, sexual, emotional.
- Witnessing domestic abuse or community violence.
- Bullying.
- Traumatic loss.
- Medical trauma.
- Natural disasters.
- War and terrorism.
- Refugee trauma.
INTRODUCTORY CONCEPTS

DETERMINANTS OF CHILD’S RESPONSE TO TRAUMA – RESULT OF 3 SETS OF VARIABLES:

- Characteristics of the traumatic event(s)
- Characteristics of the environment
- Characteristics of the individual child
INTRODUCTORY CONCEPTS

CHARACTERISTICS OF THE TRAUMATIC EVENT(S)

- Frequency, severity, & duration of event(s)
- Degree of physical violence and bodily violation
- Level of terror and humiliation experienced
- Persistence of threat
- Physical and psychological proximity to event and perpetrator
INTRODUCTORY CONCEPTS

CHARACTERISTICS OF THE ENVIRONMENT

- Attitudes and behaviors of first responders.
- Immediate reaction of caregivers or those close to child.
- Type, quality of, & access to, constructive supports.
- Degree of safety following the event.
- Prevailing community/cultural attitudes and values.
- Other protective & risk factors in environment.
INTRODUCTORY CONCEPTS

CHARACTERISTICS OF THE INDIVIDUAL CHILD

- Age and stage of development
- Prior trauma history
- Intellectual capacity
- Strengths, coping, and resiliency skills
- Vulnerabilities (psychiatric or physical disorders).
- Child’s culturally based understanding of the trauma
INTRODUCTORY CONCEPTS

FOCUS IS ON MALTREATMENT AND LOSS, AS PRIMARY MANIFESTATIONS OF TRAUMA

- Neglect/abandonment, physical abuse, sexual abuse, emotional abuse (abuse = secrecy & shame).
- Witnessing, in home or community.
- Loss, especially traumatic loss.
- Other: disrupted caregiving, multiple placements, rejection. Possible abuse in substitute care.
1ST Theme: Childhood trauma constitutes a public health crisis, with serious consequences
1st Theme: Childhood trauma constitutes a public health crisis, with serious consequences

- Prevalence.
- Consequences.
PUBLIC HEALTH CRISIS

PREVALENCE OF CHILDHOOD TRAUMA (VARIOUS STUDIES)

General population: 34-53%.

Public mental health clients: 90%, most multiple exposures.

Adolescents in an inpatient psychiatric hospital: 93% reported a history of trauma. 32% met full criteria for PTSD.

Los Angeles County: 88-91% of students exposed to community violence, most multiple exposures.
AGGREGATE NATIONAL STATISTICS ON CHILD ABUSE AND NEGLECT (1995, CWLA & NCTSN)

- Reports of abuse and neglect = 3 million
- Confirmed reports = 1.1 million
- Serious Injuries = 565,000
- Fatalities = 2,000
PUBLIC HEALTH CRISIS

DISTRIBUTION OF TYPES OF REPORTED CHILD ABUSE

- Neglect = 54% (per 1998 figures).
- Physical abuse = 22%.
- Sexual abuse = 8%.
- Emotional abuse = 4%.
- Other = 12%.
CHILDHOOD TRAUMA AMONG YOUTH IN JUVENILE JUSTICE

- 93% of males, and 84% of females, experienced one or more traumatic events.
- Degree of witnessing – of violence or death:
  - 59% males.
  - 47% females.
- Chapman & Ford study, juvenile detention, CT:
  - 37% reported at least 2 types of exposure.
PUBLIC HEALTH CRISIS

CHILDHOOD TRAUMA AMONG YOUTH IN JJ – GENDER CONSIDERATIONS

- Prevalence in adjudicated females (two studies):
  - Over 75% of adjudicated females reported sexual abuse.
  - Over 90% of incarcerated females reported childhood maltreatment.
- Males – more often threatened with weapon.
- Females – more often sexually assaulted.
PUBLIC HEALTH CRISIS

ADVERSE CHILD EXPERIENCES (ACE) STUDY

- Kaiser Permanente, California, starting in 1995.
- Middle class population; ongoing longitudinal study.
- Outcomes tracked for adults and youth.
KEY FINDINGS OF THE ACE STUDY

- A graded relationship between number of categories of exposure (ACE score) and negative outcomes, as adult.
- Negative outcomes include: health risk behaviors, poor health status with medical disorders, and psychiatric disorders.
- Graded relationship between number exposures & health risk behaviors/outcomes during childhood & adolescence (smoking, SUD, sex, suicide attempts).
PUBLIC HEALTH CRISIS

TRAUMA AS PRECURSOR TO ARREST & VIOLENCE

- **Arrest**, as consequence of childhood abuse or neglect:
  - As *juvenile*, 53% more likely.
  - As *young adult*, 38% more likely.
- **Violent crime** leading to arrest: 38% more likely.
PUBLIC HEALTH CRISIS

STUDY OF DANGEROUSLY VIOLENT YOUTH, GRADES 9-12

- Males: 3-6x more likely than males controls to have experienced or witnessed high levels of violence.
- Females: 2-7 times more likely than female controls to have been exposed to violence.

Higher risk for depression & suicidality than males.
PUBLIC HEALTH CRISIS

POTENTIAL BASIS FOR YOUTH VIOLENCE

- The trauma response (hyperarousal).
- Residual anger.
- Lack of trust.
- Impulsivity.
- Misperceptions.
- Impaired judgment.
PUBLIC HEALTH CRISIS

YOUTH VIOLENCE (2)

- Concerns about survival.
- Aggression as attempt at self-preservation.
- Response to shaming and provocation.
- Negative prior role models.
- Lack of effective social and problem-solving skills.
PUBLIC HEALTH CRISIS

VICTIMS AND VICTIMIZERS: THE REALITY

- Many juvenile offenders previously were victimized.
- Childhood and youth victims at higher risk of becoming offenders.
- Potential cycle of life experiences and roles. Philadelphia police: 90% of city’s murderers – and 90% of homicide victims – had prison records.
- Implication: Victimization, when not responded to, can increase further victimization and violence.
PUBLIC HEALTH CRISIS

MEDICAL & PHYSICAL HEALTH CONSEQUENCES – DURING CHILDHOOD

- Neurobiological dysregulation, impaired brain growth/function.
- Head trauma, developmental disabilities (25%).
- Sexually transmitted diseases/HIV, pelvic pain, unwanted pregnancy.
- Physical disabilities, elevated blood pressure.
- Various: headaches, stomach pain, nausea, sleep problems, eating disorders, asthma, shortness of breath, muscle tension/spasms.
PUBLIC HEALTH CRISIS

MEDICAL & PHYSICAL HEALTH CONSEQUENCES – DURING ADULTHOOD

- Smoking, physical inactivity, overeating, obesity.
- Use of drugs and alcohol, co-occurring disorders, smoking.
- Multiple sexual partners, STDs.
- Ischemia, chronic lung disease, skeletal fractures.
- Liver disease, autoimmune disorders, cancer.
- Shortened life span.
PUBLIC HEALTH CRISIS

FREQUENCY OF ADULT PSYCHIATRIC DISORDERS

- Affective disorder: almost 3 times more likely.
- Anxiety disorder (inc. PTSD): almost 3x more likely.
- Phobia: almost 2½ x more likely.
- Panic disorder: more than 10x more likely.
- Antisocial personality disorder: 4x more likely.
- Self-harm: suicide attempts, cutting, self-starving.
- Auditory hallucinations and Schizophrenia.
PUBLIC HEALTH CRISIS

CORRELATES FOR HIGH SUICIDE RISK

- Recurrent mood disorder.
- Co-occurring mood and substance use disorder.
- Previous suicide attempt.
- Female gender.
- Personality disorder.
- History of traumatic exposure.
- PTSD.
PUBLIC HEALTH CRISIS

FREQUENCY OF PTSD IN PERSONS WITH SUBSTANCE ABUSE (CO-OCCURRING)

- Up to 67% males & females seeking substance abuse Rx have PTSD – complete or partial.
- 40-59% of women in substance abuse treatment have PTSD.
- Many more with trauma histories without full criteria for PTSD.
PUBLIC HEALTH CRISIS

ADDITIONAL CONSEQUENCES FOR FEMALES

- Childhood violence = rape 3-4 times more likely.
- Childhood sexual abuse = sexual re-victimization 2-4 x more likely. Domestic abuse x 2 more likely.
- High likelihood of depression, suicidality, and lack of empathy.
- Result = multi-generational cycle, with 33% of abused women neglecting or abusing own children.
PUBLIC HEALTH CRISIS

NEUROBIOLOGICAL CONSEQUENCES
PUBLIC HEALTH CRISIS

EFFECTS OF TRAUMA ON THE BRAIN – NEUROBIOLOGICAL DYSFUNCTION

- Severe, prolonged childhood abuse damages the developing brain via neurochemical, structural, and functional changes.
- These changes disrupt normal development.
- Structural changes potentially irreversible, although brain continues to mature into mid-20’s.
TWO BASIC SURVIVAL RESPONSES TO DANGER AND THREAT (NORMAL PROCESSES):

- Hyperarousal responses: “fight” or “flight,” in support of active mastery and/or
- Dissociation responses: passive, surrender response, to escape/avoid situation.

- Both responses are normal and of adaptive benefit, increasing the likelihood of survival.
THE HYPERAROUSAL RESPONSE:

- Either “fight” or “flight,” enables individuals to take emergency action in response to fear, terror, and danger.
  - “Fight” = self-defense.
  - “Flight” = removing self from danger.

- Mediating neurobiology: Catecholamines – adrenaline and noradrenaline – and hypothalamic pituitary axis.
THE HYPERAROUSAL RESPONSE (2):

- Physiological responses:
  - Increased heart rate.
  - Increased blood pressure.
  - Increased energy availability in skeletal muscles.

- Observable manifestations:
  - Highly focused attention
  - Sweating
  - Erect posture
PUBLIC HEALTH CRISIS

THE DISSOCIATION RESPONSE

- Dissociation = “disengaging from stimuli in the external world and attending to an internal world” (Perry et al, 1995), to “camouflage” self and buy time
- Dissociation involves emotional numbing and withdrawal.
- A dissociation continuum, depending on trauma severity and circumstances.
- Mediating neurobiology: Increase in vagal tone.
THE DISSOCIATION RESPONSE (2)

- Physiological responses:
  - Decrease in heart rate.
  - Decrease in blood pressure.

- Observable manifestations:
  - Decreased movement
  - Compliance
  - Avoidance
  - Restrictive affect
PUBLIC HEALTH CRISIS

DYSREGULATION OF AROUSAL SYSTEM, FOLLOWING SEVERE, CHRONIC TRAUMA

- Hyperarousal the primary problem.
- Previously adaptive response becomes maladaptive.
- Adaptive emergency “state” becomes maladaptive “trait.”
- Problem with: baseline, threshold for activation, turnoff, baseline, & future reactivation.
- Result = Impaired capacity for self-regulation.
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VARIABLE RESPONSES TO DANGER & THREAT

- Young children, and females, tend to dissociate.
- Older children and adolescents tend to become hyperaroused.
- Same individual may use both types of responses.
- Aggressive responses = hyperarousal.
- Lack of responsiveness/apparent disinterest may = dissociation.
- Responses by child can change over time.
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SPECIFIC STRUCTURAL CHANGES ASSOCIATED WITH SEVERE TRAUMA AND PTSD (DeBellis):

- Smaller brain volumes (decreased function):
  - Overall brain size & parts of brain connecting hemispheres.
  - Intracranial growth occurs early: 75% of adult brain volume by age 2, and 100% by age 10. (Carmichael, 1990).

- Larger volumes of ventricles (e.g., spaces).

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CONCEPT OF NEUROBIOLOGICAL REGRESSION – “THE TRAUMA RESPONSE” (PERRY)

- Retreat from cortex to less mature levels of brain functioning & behavior, in response to trauma.
- Pathway of retreat: cortex to limbic system; to midbrain; extreme terror = brainstem.
- Frontal cortex bypassed. Self-regulation impaired.
- Global processes affected: recognition & response to danger, self-regulation, memory, attention, processing emotional information, impulse control, planning, learning from experience.
PUBLIC HEALTH CRISIS

MANIFESTATIONS OF IMPAIRED SELF-REGULATION

- Internal discomfort.
- Impaired daily functioning.
- Impaired learning & problem solving.
- Impaired ability to form relationships.
- Impaired ability to develop/show empathy.
- Impacts behavior, beliefs, & values.
PUBLIC HEALTH CRISIS

DESPITE IMPACT OF TRAUMA, “GOOD NEWS”
- Brain growth/differentiation through mid-20’s.
- “Choose it and use it” as antidote to “use it or lose it.”
- Possible to create new cognitive, emotional, & neural pathways.
- Positive life experiences & relationships promote brain development.
- Mental health recovery can guide brain recovery.
- Relationships = more neural circuits.
PUBLIC HEALTH CRISIS

OTHER CONSEQUENCES OF TRAUMA ON CHILDREN AND YOUTH
PUBLIC HEALTH CRISIS

UNDERLYING BELIEFS OF YOUTH

- “The world is threatening and bewildering.”
- “The world is punitive, judgmental, and blaming.”
- “People are unpredictable.”
- “Very few are to be trusted.”
- “I don’t have control over my life.”
- “My survival is uncertain.”
- “If I admit a mistake, things will be worse.”
- When challenged, I must defend my honor & self-respect.”
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COMMON PRESENTATION OF YOUTH SUBJECTED TO SEVERE TRAUMA

- Lack of trust.
- Guardedness.
- Hyper-vigilance.
- Startle response.
- Dislike for being touched.
- Over-reaction.
- Urgency.
- Anger & rage.
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COMMON PRESENTATION OF YOUTH (2)

- Impulsivity.
- Limited “executive skills” (analyze, problem-solve, self-regulation).
- Misperceptions.
- Limited capacity to verbalize, especially feelings.
- Reluctance to ask for help.
- Low frustration tolerance.
- Academic limitations.
PUBLIC HEALTH CRISIS

COMMON PRESENTATION OF YOUTH (3)

- Lack of future orientation.
- Materialistic concerns.
- Hypersensitivity to shame & humiliation.
- Being “dissed” provokes violence.
- Violence often a result of impulsivity.
- Risk of arrest and incarceration.
- Risk of death.
PUBLIC HEALTH CRISIS

YOUTH ARE OFTEN MISUNDERSTOOD

- By self: Not understand own behavior.
- By parents: Infer intentionality.
- By professionals: Responses can exacerbate the problem.
- E.B Carlson:

  ...aggressive behavior is less akin to the willful defiance of an obstinate (child) than the response of a frightened child to his or her experience of traumatic violence.
NEED TO RECOGNIZE YOUTH STRENGTHS (1)

- Very aware of how treated.
- Strong survival skills.
- Strong concept of fairness and justice.
- Passion common.
- Typically responsive to respectful adults.
- Capable of loyalty.
- In search of personal control and mastery.
YOUTH STRENGTHS (2)

- Identify strengths unique for each youth.
- Complete strengths inventory for each youth, to determine specific areas of competence.
- Triad for strengths inventory: past accomplishments, current strengths/interests, & future goals.
- Obtain information from both youth and family.
- Strengths determination useful for treatment planning and for establishing a connection.
PUBLIC HEALTH CRISIS

MOST USEFUL ASSUMPTIONS RE YOUTH

- Youth doing the best they can at the time, with what they have.
- Youth would like to do better.
- Four types of limitations – knowledge, stability, support, skills.
- Need for strengths based interventions.
TRAUMA INFORMED CARE

2nd Theme: Trauma informed care is an organizing principle of care
2nd Theme: Trauma informed care is an organizing principle of care

- Definition.
- Characteristics.
- Implementation.
TRAUMA INFORMED CARE

TRAUMA INFORMED CARE – DEFINITION

*Trauma informed care* involves the provision of interventions informed by an understanding of the pervasiveness of trauma and its consequences. TIC addresses the symptoms and core deficits related to the traumatic experience, avoids possible re-traumatization, and promotes the individual’s self-awareness, self-regulation, & healthy functioning.
“Trauma informed” services are not specifically designed to treat symptoms or syndromes related to sexual or physical abuse or other trauma, but they are informed about, and sensitive to, trauma-related issues present in survivors. All components of a given service system have been reconsidered and evaluated in light of a basic understanding of the role that violence plays in the lives of people.
ANN JENNINGS’ OVERVIEW (2) – KEY ELEMENTS OF TRAUMA INFORMED SERVICES:

- Services accommodate the vulnerabilities of trauma survivors.
- Inadvertent re-traumatization is avoided.
- Youth participation & empowerment are promoted.
- Closely knit, collaborative relationships are developed with other systems serving the youth.
TRAUMA INFORMED CARE OPERATES AT MULTIPLE LEVELS, INCORPORATES MODELS:

- Harm reduction (avoiding restraints & coercion).
- Medical level (addressing neurobiology).
- Rehabilitation level (promoting skills & functioning).
- Recovery level (promoting choices and meaning in life).
The level of individual physiology, with particular attention to issues of arousal and self-regulation.

The larger social-environmental level, to mitigate conditions that produce or sustain maladaptive traumatic reactions.
TRAUMA INFORMED CARE

KEY CHARACTERISTICS OF TRAUMA INFORMED CARE

- TIC not require highly specialized MH expertise.
- Applicable to any setting & level of care, and the community.
- Encompasses both prevention & crisis intervention.
- Benefits both individuals and groups.
- TIC is “value added,” not a stand-alone approach.
Individuals, and juveniles in particular, respond best to encouragement & respect.

Humiliation and shaming are counter-productive. Threats by others produce defiance or violence by juvenile (Newton’s law of psychological gravity).

James Gilligan: “The purpose of violence is to force respect from other people.”
TRAUMA INFORMED CARE

TIC INVOLVES AVOIDING USE OF SECLUSION AND RESTRAINT – ONE CLEAR APPLICATION

- S/R re-traumatizing and non-therapeutic – used only an emergency intervention of last resort.
- Use of S/R can also traumatize staff and observers.
- S/R reduction & elimination part of broader commitment to avoid interpersonal coercion.
- Coercion models violence, not collaboration.
- Coercion models power rather than reason.
TRAUMA INFORMED CARE

THREE COMPLEMENTARY PERSPECTIVES ON TIC

- “ARC” – National Child Traumatic Stress Network.
- “SELF” – Sanctuary Model (Bloom)
- “Nine C’s of Trauma Informed Care” – Hodas.
TRAUMA INFORMED CARE

“ARC” MODEL, NATIONAL CHILD TRAUMATIC STRESS NETWORK, FOR COMPLEX TRAUMA

- “A” = Attachments
- “R” = Regulatory capacity
- “C” = Competencies across multiple domains

Schools, residential settings, and communities are all potentially protective for children, can actively promote all 3 components of the ARC model.
TRAUMA INFORMED CARE

“SELF” – SANCTUARY MODEL (BLOOM)

- “S” = Safety (physical, psychological, social, moral)
- “E” = Emotions (handling feelings constructively)
- “L” = Loss (addressing loss, grieving)
- “F” = Future (making choices and planning)
TRAUMA INFORMED CARE

THE “9 C’s” OF TRAUMA INFORMED CARE (Hodas)

- Coercion – to be avoided (the rest, promoted).
- Collaboration – partnership between child and staff.
- Control – internal locus of control for child.
- Choice – opportunities for meaningful decisions.
- Cultural competence – accepting child/family beliefs and preferences.
THE “9 C’s” OF TRAUMA INFORMED CARE

- Connection – sense of affiliation & interdependence.
- Comprehension -- self-awareness & knowledge.
- Competence – acquisition of skill sets for relationships, problem-solving, tolerating frustration.
- Contentment – personal meaning & sense of purpose, an outcome of other 8 elements.
IMPLEMENTING TRAUMA INFORMED CARE

- Trauma informed beliefs
- Trauma informed practices
TRAUMA INFORMED CARE

TRAUMA INFORMED BELIEFS

- “Negative behaviors” have been adaptive.
- “Negative behaviors” may also be default responses.
- “Manipulative youth” often feel very *out of control*.
- Seemingly intentional behavior often is not.
- Power struggles are to be avoided.
- The core consideration involves *avoidance of shame and humiliation*. 
TRAUMA INFORMED CARE

TRAUMA INFORMED BELIEFS (2)

- Youth needs assistance in acquiring new skills.
- Youth needs trusting, therapeutic relationships. “therapeutic” = of therapeutic benefit.
- Youth needs information and self-awareness.
- Youth needs support in developing realistic, prosocial goals.
- Youth needs help in regaining/acquiring hope.
TRAUMA INFORMED CARE

TRAUMA INFORMED PRACTICES (1)

- Determine if externally based trauma or danger continues. Dangerous for child give up defenses, when still needed for safety.
- Actively engage and build relationships.
- Build on youth and family strengths.
- Be a role model for appropriate behavior – persona.
- Obtain a trauma history and a treatment history.
- Anticipate needs, and intervene early.
TRAUMA INFORMED CARE

TRAUMA INFORMED PRACTICES (2)

- Ensure clinical treatment is available & appropriate.
- Help youth understand trauma history, symptoms & behaviors, impact on life, and how to change.
- Help youth learn to recognize & control triggers.
- Promote self-expression and a belief in words.
- Promote acquisition of social skills.
- Promote coping and wellness.
TRAUMA INFORMED CARE

TRAUMA INFORMED PRACTICES (3)

- Avoid intimidation, coercion, and violence.
- Provide ongoing support and encouragement.
- Use self to redirect and de-escalate.
- Avoid S/R and coercion.
- Use the milieu to address and resolve issues.
- Focus on “what you went through,” not “what’s wrong with you.”
- Approach “failures” as opportunity for new learning.
OTHER RELEVANT INTERVENTIONS

- Treatment of other psychiatric disorders.
- Treatment of co-occurring SUD, if present.
- Use of psychotropic medication, as indicated.
- Working with family and community.
- Trauma-specific Rx (CBT), when indicated.
- Gender-specific approaches & gender resocialization.
TRAUMA INFORMED CARE

SPECIAL CONSIDERATION – TRAUMA INFORMED CARE FOR FEMALES (1)

- Ensure physical & emotional safety.
- Monitoring for depression and suicidality.
- Periodic assessment, not one-time events.
- Refer to psychiatrist based on signs of: PTSD, depression, suicidality, psychosis, self-injurious behaviors, other serious symptoms.
- Safety contracts & one-to-one staffing, as needed.
TRAUMA INFORMED CARE

TRAUMA INFORMED CARE FOR FEMALES (2)

- Address drug and alcohol problems, as indicated.
- Address co-existing psychiatric disorders.
- Offer psychotropic medication, when indicated.
- Ensure that staff is not threatening or demeaning.
- Ensure male staff don’t sexually exploit females.
- Ensure that all staff understand the dynamics of trauma and TIC, as related to females.
TRAUMA INFORMED CARE

TRAUMA INFORMED CARE FOR FEMALES (3)

- Help female understand the dynamics of trauma and links between past trauma & current challenges.
- Offer age-appropriate information on wellness, lifestyle choices, and sexuality.
- Teach skills that support healthy, non-exploitative relationships with males.
- Teach parenting skills to pregnant females or those with children.
TRAUMA INFORMED CARE

TRAUMA INFORMED CARE FOR FEMALES (4)

- Help female maintain contact with trusted family members.
- Support capacity of females to affiliate with and support one another.
- Offer trauma-specific therapy for those with serious symptoms related to sexual abuse or rape.
- Direct special attention to minority females.
CROSS SYSTEM IMPLEMENTATION

3rd Theme: Trauma informed care can be implemented in multiple systems and settings
3rd Theme: Trauma informed care can be implemented in multiple systems and settings

- Congruence of TIC with public health approach.
- Implementation in multiple systems and settings.
- Implications for culture and socialization process.
- What TIC feels like. no
- What you can do. no
Public health interventions extend beyond concern for individuals and provision of clinical treatment.

Public health embraces prevention at multiple levels.

Attention to risk & protective factors, & promotion normal developmental processes.

Effective public health involves coordinated efforts by many systems.
CROSS SYSTEM IMPLEMENTATION

TIC AND THE PUBLIC HEALTH APPROACH (2)

- Three levels of public health “prevention”:
  - Primary prevention – for everyone, to prevent emergence of disorders or crises.
  - Secondary prevention – for at risk groups, to prevent full-blown emergence of disorder or crisis.
  - Tertiary prevention – clinical treatment, and learning from incidents with goal of prevention.
- TIC is congruent with a public health approach.
CROSS SYSTEM IMPLEMENTATION

TIC IN MULTIPLE SYSTEMS & SETTINGS

- MH – Inpatient, RTF, PHP, CRR, independent living
- C&Y – shelter care, foster care, community
- JJ – juvenile detention, secure treatment facilities, special forensic and MH units, community
- Adult legal system – incarceration, reintegration
- D&A – rehab, residential, Outpatient
- Education
- Community-based settings
CROSS SYSTEM IMPLEMENTATION

TIC IN COMMUNITY BASED SETTINGS

- TIC in community-based MH.
- TIC in Regular Education and Special Education.
- TIC by courts (consistent with BARJ)– diversion, competency development, use of natural supports, preventing re-traumatization.
- TIC by family, community leaders, coaches, etc.
CROSS SYSTEM IMPLEMENTATION

PREREQUISITES FOR TIC FOR ANY AGENCY – COMPONENTS OF POSITIVE CULTURE & TEAM

- Commitment to maintain mutual respect.
- Willingness to examine agency culture & practices.
- Capacity to tolerate – and embrace – disagreement.
- Recognition of contribution of every team member.
- Transparent agency process – no hidden agendas.
- Capacity to achieve consensus and follow through.
CROSS SYSTEM IMPLEMENTATION

ESSENTIAL PROGRAM COMPONENTS FOR A TRAUMA INFORMED AGENCY

- Safety of youth ensured.
- Use of strengths based, collaborative approach.
- Biopsychosocial Rx addresses individual, not just behavior.
- TIC provided to individual youth & larger group.
- Youth helped to learn how to use services & Rx.
- Formal restraint commitment & use of TI tools.
- Trauma specific treatment, provided as needed.
CROSS SYSTEM IMPLEMENTATION

TIC TOOLS AND STRATEGIES

- Trauma history and trauma screening
- Risk assessment for violence
- Risk assessment for use of restraint
- Safety plan
- Workforce hiring, training, supervision
- Use of data
CROSS SYSTEM IMPLEMENTATION

TRAUMA HISTORY AND TRAUMA SCREENS

- Trauma history critical part of every evaluation or face-to-face assessment.
- Many trauma screens available for children & youth.
- Some completed by youth. Some with parent forms.
- Some address trauma exposure/experience.
- Some address symptom presence & severity.
- Some attempt to do both.
- Need to incorporate information into Rx plan & use.
CROSS SYSTEM IMPLEMENTATION

RISK ASSESSMENT FOR VIOLENCE

- No single tool with consistent predictive capacity.
- Information needed, nevertheless.
- High risk factors include:
  - History of previous assaultive behavior.
  - Threats of violence, or evidence of plans to harm.
  - Psychosis, including command hallucinations.
  - Substance use or intoxication.
  - Male gender, few social supports.
RISK ASSESSMENT FOR USE OF RESTRAINT

- For some, specific techniques to be avoided.
- For others, restraint contraindicated entirely.
- Potential psychiatric/psychological factors:
  - Past sexual or physical abuse
  - Past traumatic restraint experience, or physical struggle
- Potential physical and medical factors:
  - Pregnancy
  - Breathing or cardiac problem, head trauma, skeletal injury or malformation, bleeding disorder, etc.
CROSS SYSTEM IMPLEMENTATION

SAFETY PLAN – ADDRESSES

- Youth’s way of calming self, “chilling.”
- Likely triggers and precipitants of “vapor lock.”
- Signs and symptoms of vapor lock.
- What youth wants staff to do, and not to do.
- What youth wants to be encouraged to do.
- Identification of others who can provide support.
- Development of safety plan collaborative, part of Rx.
CROSS SYSTEM IMPLEMENTATION

WORKFORCE ISSUES (1)

- Training helps staff buy-in and builds skills.
- Choose, or develop, an organized curriculum.
- Respect and mentor staff.
- Staff respect residents when they feel respected.
- Follow trauma informed hiring practices – not everyone should work with children.
WORKFORCE ISSUES (2)

- Incorporate TIC into written job descriptions.
- Help staff understand impact of trauma, so child’s behavior not seen as intentional & spiteful.
- Maintain focus on TIC in training & supervision.
- Include TIC-related skills in performance evaluation.
- Teach, and have staff practice, de-escalation skills.
- Use shadowing, role playing, informal discussion.
CROSS SYSTEM IMPLEMENTATION

COLLECTING AND USING DATA

- Effective programs are guided by data, trends, & commitment to quality improvement process.
- Need to determine what data to collect, related to restraint, injuries (youth and staff), runaways, hospitalizations, contacting police, dismissals, etc.
- Need common definitions, understood by all.
- Need commitment to report accurately.
- Need involvement of leadership team.
CROSS SYSTEM IMPLEMENTATION

BEYOND “TOOLS” & INFORMATION, ALSO NEED

- Engagement and orientation of youth and family.
- Understanding of youth & family story/perspectives.
- Hypothesis, or formulation – what’s going on.
- Developing hypothesis with youth and family.
- A common language for staff and youth.
- Focus on more than points, behavior, & compliance.
- Frequent use of core themes.
CROSS SYSTEM IMPLEMENTATION

INDICATORS OF TRAUMA INSENSITIVITY

(Fallot & Harris; Massachusetts DMH; Huckshorn; Hodas)

- Children pathologized as “manipulative,” “attention-seeking,” or “bad.”
- Misuse/overuse of displays of power – demeanor, keys, security, points & levels.
- Culture of secrecy – poor monitoring, under-reporting, accountability discouraged.
CROSS SYSTEM IMPLEMENTATION

TRAUMA INSENSITIVITY (2)

- Staff sees key role as being an enforcer.
- Emphasis on “compliance” rather than collaboration.
- Compliance via threats and/or withholding privileges.
- Trauma history not obtained, or disregarded.
- Shaming used intentionally, or without recognition.
- “Tough love” and “putting child in his/her place.”
CROSS SYSTEM IMPLEMENTATION

TIC TO PROMOTE MALE RESOCIALIZATION

- A theme of the men’s movement in 1980’s-1990’s.
- Core ideas embraced by others.
- A primary prevention strategy.
- De-emphasizing power, competition, conquest, vengeance, in favor of feeling, caring, kindness.
- Best achieved through modeling, not just words.
- Important voices include Joe Ehrmann and Geoffrey Canada.

- From Pro-Bowl football “good old boy” to minister with concern about destructive male socialization.
- Redefining essence of masculinity – from aggression and self-preoccupation to “a man built for others.”
- Joe Ehrmann & Biff Poggi, to Gilman HS football tm:
  - What is our job? Most of the boys: To love us.
  - And what is your job? Boys: To love each other.
At Rheedlen, we make sure our programs have mature and caring men in them, both young and old…Our boys see men holding children’s hands, wiping their tears away, reading them stories… (The boys) grow up knowing how normal it is for men to show concern, love, and tenderness for children.
CONCLUSIONS

- Review: What TIC is and is not.
- Outcomes of TIC, as experienced by youth.
- How TIC can reduce acts of violence.
- What you can do.
- Self-assessment for agencies and ourselves.
CONCLUSIONS

WHAT TRAUMA INFORMED CARE IS

- A principle of care applicable to a broad range of stakeholders in multiple systems & the community.
- An opportunity to respond to a significant public health problem.
- A way to avoid retraumatization, when working with youth.
- A guide to interventions that does not “excuse” behavior, but helps individuals make better choices.
CONCLUSIONS

WHAT TRAUMA INFORMED CARE IS NOT

- A single program or intervention to be implemented without substantial information and team planning.
- A manual-based, clinical treatment for only a few.
- A rationale for abandoning youth responsibility & accountability, or for jeopardizing community safety.
- A panacea for the complex needs of individuals with complex life experiences and challenges.
The subjective experience of trauma informed care is transformational.

The transformation involves a shift from previous experiences to a renewed experience.
CONCLUSIONS

Outcomes of Trauma Informed Care (Hodas)

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Danger</td>
<td>Safety</td>
</tr>
<tr>
<td>Fear</td>
<td>Security</td>
</tr>
<tr>
<td>Uncertainty</td>
<td>Predictability</td>
</tr>
<tr>
<td>Confusion</td>
<td>Understanding</td>
</tr>
<tr>
<td>Disrespected</td>
<td>Respected</td>
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</tbody>
</table>
CONCLUSIONS

Outcomes of Trauma Informed Care (2)

<table>
<thead>
<tr>
<th>From</th>
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<tbody>
<tr>
<td>Coerced</td>
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<tr>
<td>Threatened</td>
<td>Reassured</td>
</tr>
<tr>
<td>Rejected</td>
<td>Accepted</td>
</tr>
<tr>
<td>Unequal</td>
<td>Partner</td>
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</tbody>
</table>
CONCLUSIONS

Outcomes of Trauma Informed Care (3)

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperaroused</td>
<td>Calm</td>
</tr>
<tr>
<td>Reactive</td>
<td>Reflective</td>
</tr>
<tr>
<td>Fragmented</td>
<td>Coherent</td>
</tr>
<tr>
<td>Mistrusting</td>
<td>Trusting</td>
</tr>
</tbody>
</table>
CONCLUSIONS

Outcomes of Trauma Informed Care (4)

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
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</thead>
<tbody>
<tr>
<td>Fragile</td>
<td>Resilient</td>
</tr>
<tr>
<td>Victim</td>
<td>Survivor</td>
</tr>
<tr>
<td>Isolated</td>
<td>Connected</td>
</tr>
<tr>
<td>Overpowered</td>
<td>Empowered</td>
</tr>
<tr>
<td>Violent</td>
<td>Verbal</td>
</tr>
</tbody>
</table>
CONCLUSIONS

REDUCING VIOLENCE – WHY TIC CAN HELP

- Relationships heal & restore hope.
- Collaboration & partnership promote motivation.
- Self-awareness creates opportunity for change.
- Skill development provides tools for change.
- Neurobiology changes – thermostat reset.
- As life gains meaning and genuine relationships matter, empathy can develop and change behavior.
CONCLUSIONS

WHAT YOU CAN DO (1)

- Understand that trauma is a central, life-organizing experience, which impairs neurobiological function & normal development.
- Implement trauma informed care at both the programmatic level and the individual student level.
- Provide appropriate clinical Rx for BH problems.
- Offer trauma specific treatment, when needed.
CONCLUSIONS

WHAT YOU CAN DO (2)

- Accept the youth where he/she is at.
- Make sure your expectations for youth are realistic and achievable – different for each youth.
- Maintain youth accountability calmly & respectfully.
- Avoid intimidation, humiliation, shaming, and punitive responses.
- Be aware of your attitudes and reactions.
CONCLUSIONS

WHAT YOU CAN DO (3)

- Work hard to develop trusting relationships.
- Help youth see you as an ally.
- Be “a carrier of hope,” when the youth lacks hope.
- Discover the person behind the persona.
- Try to understand why the student might have responded as he/she did.
- Be alert to signs of crisis and act early.
CONCLUSIONS

WHAT YOU CAN DO (4)

- Model qualities that the youth needs to learn.
- Promote competence and skill-building.
- Help youth reduce inappropriate risk-taking and associate with positive people.
- Help youth identify meaningful goals.
- Encourage youth to persist.
CONCLUSION

SELF ASSESSMENT

- For agency
- For ourselves
CONCLUSION

QUESTIONS FOR AGENCY SELF-ASSESSMENT REGARDING RESTRAINT REDUCTION

- What steps has agency taken to achieve TIC?
- How has the initiative been formalized?
- What parts of agency culture & practice support TIC – e.g. specific elements of positive agency culture?
- What parts of culture & practice need to change?
- What approaches have been used to educate direct care staff and promote staff buy-in?
CONCLUSION

AGENCY SELF-ASSESSMENT QUESTIONS (2)

- Collaboration with other agency/system partners?
- Collaboration with youth & families?
- Areas of greatest progress to date?
- Areas of greatest challenge and barriers?
- Methods to monitor progress & address challenges?
- Agency response to outlier youth?
- Next steps envisioned for the program?
- Current plan to get there?
CONCLUSION

PRACTITIONER SELF-ASSESSMENT QUESTIONS

- Am I aware of my values, beliefs, & biases, and how they affect my interactions with youth and families?
- Do I understand that I have chosen a stressful job?
- Do I recognize which youth, and what youth behaviors, are most likely to upset me?
- Do I maintain a welcoming, accessible persona?
- Do I listen to and maintain respect with youth and families?
CONCLUSION

PRACTITIONER SELF-ASSESSMENT (2)

- Am I open to learning about other people’s cultures?
- Do I recognize the difference between internal reactions & external responses (actual behavior)?
- Am I able to maintain self-control?
- Do I know when to remove myself from a situation?
- Am I accepting of input from others?
- Am I willing to ask for support?
CONCLUSION

PRACTITIONER SELF-ASSESSMENT (3)

- Do I continually remind myself why I have chosen to do this challenging work?
- Do I have a sense of purpose and mission?
- Closing thought:
  
  *If you have a mission,*  
  *Then why not become a missionary?*  
  *Spread the word!*
REFERENCES

SUGGESTED CHILDHOOD TRAUMA REFERENCE


  Easy access via web search: “Hodas” with “NASMHPD”

-Multiple additional references are identified at the end of the above paper.
REFERENCES

SUGGESTED REFERENCE – CBITS

REFERENCES

TRAUMA SCREENING

REFERENCES

GENDER RESOCIALIZATION

REFERENCES

INTERPERSONAL VIOLENCE
