# Trauma-Informed Care

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“Remember there’s no such thing as a small act of kindness. Every act creates a ripple with no logical end.”

Scott Adams

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## Why is an understanding of trauma important?

The prevalence of childhood exposure to trauma is startling, and it is well-documented that undiagnosed and untreated traumatic experiences in childhood may subsequently lead to serious psychological impairments as a result of but not always obviously related to the traumatic events. To treat childhood psychiatric and behavioral symptoms appropriately, it is important to understand how the effects of traumatic exposure manifest in children and adolescents and to ensure that our treatments reflect our understanding (van der Kolk, 2005; van der Kolk et al., 2005; Spinazzola et al., 2005).

According to the American Academy of Child and Adolescent Psychiatry (AACAP), most children experience stressful events at some point in their lives that affect them emotionally and physically. Children usually react briefly to mild stress and then recover without additional problems, especially in the context of secure attachment. The more safe and secure the attachment relationships, the more resilience children seem to have in the face of stress. However, a child who experiences an overwhelming or catastrophic event, or series of events (as in domestic violence, child physical or sexual abuse, or neglect) without adequate support or secure attachment, is at risk to

develop ongoing difficulties attributable to the trauma, including post-traumatic stress disorder (PTSD), complex PTSD, or Disorders of Extreme Stress (DESNOS). AACAP states, "A child's risk of developing PTSD is related to the seriousness of the trauma, whether the trauma is repeated, the child's proximity to the trauma, and his/her relationship to the victim(s)." A child who is threatened or abused repeatedly by an immediate family member, who also witnesses other family members being mistreated, who is often left at home alone to care for himself or herself, who suffers other traumatic experiences as a result of the lack of supervision (being molested by a babysitter, bitten by a dog, hurt in a preventable accident) will be at risk for more severe PTSD symptoms or trauma related disorders that appear initially to be behavioral problems but, in fact, reflect the impact of trauma and neglect (AACAP Facts for Families, 1999). Trauma-related disorders may include oppositional defiant disorder, conduct disorder, anxiety and panic disorders, major depression, bipolar disorder, and attention deficit hyperactivity disorder.

## What is a "trauma"?

- "Psychological trauma is the unique individual experience of an event or of enduring conditions in which the individual's ability to integrate his or her emotional experience is overwhelmed (i.e., his or ability to stay present, understand what is happening, integrate the feelings, and make sense of the experience), or the individual experiences a threat to life, bodily integrity, or sanity." (Saakvitne et al., 2000)
- "Traumatization occurs when both internal and external resources are inadequate to cope with external threat." (van der Kolk, 1989)

Trauma can include many different kinds of events and conditions: from invasive medical procedures and treatments to accidents, death of a parent or sibling, exposure to neighborhood violence or natural disaster, domestic violence, threats of family violence (whether acted upon frequently or intermittently), physical and sexual abuse, and traumatic neglect (inadequate food and/or care). Trauma is also relative, that is, an event that is stressful for a four-year-old (such as being left alone and unattended for several hours) might be traumatic for an infant. In addition, the perception that one's life is in danger might also be relative. For example, a mother might know that her enraged husband will not harm the children, but the children might perceive his rage and aggression as life threatening. Because children lack the cognitive capacity to differentiate life threat from intimidating or

frightening behavior, many experiences are traumatic for them that would not traumatize a teenager or adult (e.g., being left unattended with no reassurance of the parent's return, witnessing violence, threats of violence that do not lead to action, even "frightened and frightening" behavior on the part of parents).

There have been numerous studies on the prevalence of trauma. One study estimated that as many as 90% of adult clients who receive public mental health services have trauma histories (Mueser et al., 1998). Another study revealed that 34-53% of these clients reported childhood sexual or physical abuse (Kessler et al., 1995). In addition, 3.9 million adolescents have been victims of serious reported physical assaults and almost 9 million have witnessed acts of severe violence (Kilpatrick et al., 2001). Between 3.5 and 10 million children have witnessed the abuse of their mother, and up to half are of them are victims of abuse themselves (Edleson, 1999). Though not described in these studies, millions of other children are exposed to neighborhood violence, illness or death of a parent, severe accidents or injuries, and invasive medical treatments, all of which can also result in traumatization.

## Warning signs of trauma

The role of trauma in causing and perpetuating the symptoms that we observe in children is a very new concept in the world of mental health. In fact, until 1980, there was no diagnostic category for trauma-related symptoms. Even when the

diagnosis of PTSD first appeared in the DSM, it reflected the symptoms seen in combat veterans or Hurricane Katrina victims better than the symptoms of childhood trauma.

Children rarely have flashbacks and nightmares, for example. Intrusive traumatic “memories” are likely to occur as intrusive thoughts, emotions, or behavioral reactions (e.g., refusal to go to sleep, outbursts of anger, running away when startled). Their attempts to “avoid” traumatic recall look on the surface much more like behavioral avoidance than post-traumatic reactions. Their physiological hyperarousal is more likely to manifest as aggressive or self-harming behavior than as a strong startle response or difficulty sleeping, and their sleep difficulties are likely to be either hidden due to shame or be interpreted by adults simply as resistance to bedtime. The idea of trauma as a contributor to underlying anxiety, oppositional, bipolar and depressive disorders is so new that therapeutic environments have not yet incorporated practices reflecting the likelihood that traumatic or neglectful experiences are likely to be the cause of any child’s symptoms.

Children who experience repeated trauma or chronic neglect struggle with its consequences in many different ways and may develop any number of obvious trauma-related symptoms, including intense fear, helplessness, anger, sadness, or horror; intrusive memories of the traumatic event; avoidance of any stimuli related to the event; and hyper vigilance and increased arousal. They may show intense psychological distress at exposure to anything that resembles an aspect of the event.

They may have difficulty falling asleep or concentrating and may be easily startled. Some children may become less responsive emotionally, more listless, depressed, withdrawn, and more detached from their feelings. They may become emotionally numb and unresponsive or even develop dissociative symptoms (AACAP Fact for Families, 1999; Cook et al., 2005; Teicher et al., 2002).

A child dealing with the aftermath of trauma may also experience symptoms less clearly related to the trauma, including headaches or stomachaches, sudden and extreme emotional reactions or aggressive behavior, difficulty falling or staying asleep, irritability or angry outbursts, approach-avoidance behavior in interpersonal relationships, and difficulty concentrating. The children may also engage in repetitive "play-like" behavior that unconsciously re-enacts the trauma (e.g., sexualized play, aggressive behavior with peers or toys, acting out critical or humiliating treatment). Children who have been traumatized are likely to be guarded or anxious, easily angered, and highly reactive. These children are often highly sensitive to authority or hierarchical relationships, and they may have difficulty following rules or taking responsibility for their behavior, and they may make the same behavioral mistakes over and over again. A sense of "being threatened" can quickly lead the child to an emergency stress response and loss of control over aggressive impulses, resulting in attempts to harm him or herself, acting aggressively toward others, or engaging in verbal abuse.

Most commonly, acting out or symptomatic behavior occurs when children are exposed to "traumatic triggers," stimuli that are directly or indirectly tied to the trauma. For example, enuresis or encopresis might be the result of an association between abuse and bathrooms; hyperactivity could be triggered by groups of people or authority figures; refusing to speak, running out of the room, or talking back could be the result of being asked questions or expected to know the answer in school. How are these situations triggering? Because the bathroom is often where children are abused; a family group with one or more parental authority figures is usually the context for trauma, and in such families, children are punished or humiliated if they don't know "the right answer." Thus, traumatized children most often exhibit these behaviors unintentionally, without awareness of the connection to the trauma, or they experience the behaviors as logical responses to a sense of being threatened—for example, by an authority figure.

## Understanding "trauma logic"

"Trauma logic" is the kind of logic that only makes sense if you make the trauma-related assumption that nothing good is going to happen and no one can be trusted. If the norm for them is that something bad will happen (it's just a question of what and when), then children will go a long way to get more control over that inevitability.

If professionals are not trained to recognize the connection between symptom and trauma, it should not be surprising that the children themselves fail to make those connections. For children, there is an additional obstacle: both lack of memory and attachment bonds play a role in children's lack of disclosures. Children remember impressionistically and with their bodies: they remember feelings, reactions, danger signals, or "good"/"bad" more than words. The ability to form narrative memories of events increases with age and language acquisition, but children tend to more easily remember how they felt rather than what happened. In addition, because traumatic memory tends to be fragmented, children may not have confidence in what they do remember. A famous study by Linda Williams (1995) of adults with documented child abuse histories (in the form of emergency room records) found that approximately a third had no memory of these documented incidents and another third of those who did remember the experiences reported having forgotten for significant periods of time. Brain scan studies confirm why this might happen: when adults are asked to recall traumatic events while undergoing a brain scan, the verbal memory centers in the frontal lobes shut down while nonverbal areas governing emotions and body sensations become very active. These studies suggest that children are likely to remember trauma behaviorally, emotionally, and autonomically.

Even when they do recall what happened and are invited to disclose, loyalty to family members and fear of loss, rejection, or retaliation discourages revelation. The challenge for mental

health professionals, even when they are frustrated and befuddled, is to assume that all human behavior is meant to be adaptive. No matter how bizarre, even inappropriate behaviors are at least failed attempts at adaptation. This concept has emerged from neuroscience research, which demonstrates that our behavior reflects brain development and organization. Brain development in turn has been shown to be dramatically affected by attachment experiences and environment (Shonkoff & Phillips, 2000).

The following are two examples of how behavior that was adaptive at one time is no longer useful and potentially harmful for these children:

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|---|---|
| An adolescent girl was sexually abused by her stepfather and neglected by her mother, who struggled with alcoholism. She now seeks out sexually explicit or dangerous situations. Re-enactment behavior almost always has an adaptive purpose: this teenager is seeking out a situation that she learned was bound to happen anyway, no matter what she did. Believing that sexual exploitation is inevitable, initiating the sexual contact gives her increased control over the timing and circumstances, the only control she could have had as a child. In addition, seeking out the only positive attention she may have ever known might give her some hope of connection or protection. | A 12-year-old boy was abandoned by his father and severely neglected and beaten by his mother who struggled with mental illness. He now steals from his peers and makes himself the scapegoat in social situations. If the only attention he received from his mother came when he acted out or irritated her, he is now likely to behave as if all human beings would do what he learned to expect from her, and making himself the “bad guy” offers more control, more predictability. If you are convinced of your unlovability, as a child with his history would have to be, and assume that others will never like or include you, why not pull the plug on positive relationships while you still can? If you are convinced that others have not had the losses you have had, that they have gotten the things they needed and wanted, and then you steal from them, you reclaim your loss. |

These are examples of “trauma logic.” If we use “trauma logic,” we can communicate to children that their behavior must have some logic even if we don’t understand it, that they must be trying to solve a problem rather than create one. And if, instead of reacting to the inappropriateness of the behavior, we can be curious about its logic and creativity, then we will start to invite children to be more curious. Curiosity activates the medial prefrontal cortex, a part of the brain associated with greater self-awareness and decreased impulsivity.

Because of our concerns about safety and risk management, many mental health professionals are reluctant to initiate these discussions with children. We become anxious that we will encourage or reward the behavior. But the world of neuroscience tells us differently: safety and risk management depend upon the ability of the frontal lobes to exert top-down managerial control over impulses and actions.

If we encourage curiosity about behavior, not by asking, “Why did you do it?” but by assuming, “You must have had a good reason, even if that reason doesn’t make sense right now,” then we wake up the prefrontal cortex and increase their ability to observe and learn from experience. If we *react* to the behavior by either imposing a consequence or asking “Why?” questions, we decrease the child’s ability to learn. Unfortunately, both why questions and consequences can be triggering for traumatized children, intensifying feelings of threat and shutting down the prefrontal cortex. Consequences can

always be imposed after we are curious and encourage children to be curious about what happened.

Ironically, it is actually better risk management to assume the best than the worst! It is our frontal lobes that are in charge of safety and good judgment, and curiosity is the key to bringing them on line.

## The neurobiology of trauma

Even at birth, we are "hardwired" to respond to threat or danger with specific physiological responses that maximize our chances of survival. When we perceive a threatening stimulus, our bodies mobilize emergency responses. Adrenaline activates the sympathetic nervous system to speed oxygen to muscle tissue preparing us to flee or fight, while other neurochemicals mobilize the parasympathetic nervous system to prepare us for other alternative survival responses, such as freezing, submission, and compliance.

In childhood, fight against a parent figure or flight from home and family are not usually available options, and therefore parasympathetic freezing and compliance often come to be a child's habitual ways of responding to potential danger. Over time, with repeated experiences of actual or threatened abuse or neglect, the development of specific brain pathways governing personality and emotional development may be profoundly affected. These pathways include those that enable a person to recognize and respond appropriately to danger,

to interpret new experiences, to process information, to self-regulate and self-soothe, to control impulses, and to form memories.

Under ordinary conditions, these emergency responses shut down after the danger has passed. However, in people who have been exposed to severe and ongoing trauma, the body often loses its ability to shut down the emergency response, resulting in either a continuous state of hyperarousal (as evidenced by behavior that is anxious, guarded, explosive, aggressive, reactive, hyperactive) or prolonged states of hypoarousal (associated with numbing, robotic compliance, passivity, disconnection, loss of pleasure or motivation). The survival responses that helped the child to adapt to a threatening environment tend, with overuse, to become post-traumatic symptoms and habitual problematic responses.

Human development is shaped by a dynamic and continuous interplay between biology and experience. In a traumatogenic environment, certain cues become associated with potential danger and cause the survival responses to be turned on in anticipation of abuse or threat (for example, when the front door opens, when a raised voice is overheard in the next room, when a particular model of car driven by the abuser is observed).

This sensitivity to *threat cues* helps to increase the chances for optimal survival but results in later difficulties with *stimulus discrimination*, the ability to differentiate a potential future threat from reminders of past trauma. As a result, trauma victims

often become very reactive to sensory input directly or indirectly associated with past traumatic experiences. The body responds as if the stimulus represents a life threat with sympathetic responses of panic, adrenaline rush, and hypervigilant and/or hyperactive reactivity, or, with para-sympathetic shutdown, numbing, floating away, or blanking out. On the surface, others may perceive the victim as either over-reacting or under-reacting, without realizing that these responses are the body's re-enactment of mobilization for danger (van der Kolk et al., 1996; Saxe, Ellis, & Kaplow, 2006).

As an additional complication, the child may not be aware of any connection between these reactions and the episodes of neglect and abuse he or she experienced. When the sympathetic nervous system prepares for fight or flight, the frontal lobes and the hippocampus (the parts of the brain responsible for witnessing events and organizing the memories) shut down to enable us to respond immediately and instinctively. The result is that the child is left with the emotional and body responses to the event disconnected from the knowledge that they occurred.

These responses do not "carry with them the internal sensation that something is being recalled. We act, feel, and imagine without recognition of the influence of past experience on our present reality" (Siegel, 1999). Caregivers struggle with understanding the intense and often extreme responses of traumatized children, and the children themselves do too. Asking the child, "Why did you do that?" usually only elicits

guesses or excuses that further frustrate the child and the caregiver. In addition, a child's brain does not develop the conceptual ability to meaningfully answer a 'why' question until age 12-13.

Inpatient and residential treatment programs provide services for many traumatized children. Some of the children are identified as traumatized at admission, but some are not, either because the trauma has not been reported or because the reported events have not been seen as potentially traumatic. In Massachusetts, a review of client histories in 2001 revealed that 84% of the children in continuing care inpatient hospital units and intensive residential treatment programs had reported histories of trauma (DMH Record Review, 2001).

In another study of 100 adolescents on inpatient units, 93% disclosed having a history of trauma and 32% were diagnosed with PTSD (Lipschitz et al., 1999). Children are often admitted to hospitals and residential programs because they are struggling with problematic behaviors connected to their histories of trauma, such as suicidal or parasuicidal behavior, self-injury, aggression toward others, passive aggressive behavior, loss of interest, and deep despair. Despite the large number of traumatized children in residential and hospital programs, most settings have not provided their staff members with the necessary training to offer trauma treatment or trauma-informed care.

## Assessment of trauma risk

To provide specialized trauma treatment, programs must be able to identify the potential or actual traumatic exposure of each child at intake. This goal is best met by conducting an initial assessment of a child's trauma history, with a particular emphasis on identifying any risk factors or triggers that may result in dangerous behavior. Without such an assessment, it is impossible to provide trauma-informed treatment.

Ideally, trauma assessments should include the following information:

- The type of trauma (abuse, neglect, witnessing domestic or community violence, abandonment or separation from parent figures)
- The age(s) at which the traumatic event(s) occurred
- The perpetrator(s) of the trauma, the "non-offending bystanders," and their relationship to the child
- A description of symptoms in the assessed that are commonly found in traumatized children
- A description of the most common triggers that activate the symptoms

At the same time, trauma assessment must reflect the Hippocratic principle, "Do no harm." For example, it is important to keep in mind that talking about traumatic events triggers trauma-related sympathetic and parasympathetic responses and may create an internal sense of threat for the child. It is

also threatening for children to be asked to reveal “secrets,” to “tell on” their parents, or to discuss events that they may not remember or associate with degradation and humiliation. Assessment of traumatic experiences can be done most safely by questioning adults in the child’s life, rather than the child. In general, it is more helpful to ask children general questions, such as “Does anyone at home hurt you?” or “Does anyone call you bad names?” Elicit general statements about the type of trauma and the identity of the perpetrator from the child, rather than detailed information, and elicit the more detailed information from other sources. It is also important that the assessment focus on what happened to the child, rather than on what is wrong with him/her (Bloom, 2002). The assessment becomes part of the treatment when it is used to reassure the child that his or her symptoms have meaning, that they make sense as responses to traumatic experience or as ways that the body is expressing fear and dread.

Finally, it is of utmost importance to assess the child’s current situation relative to safety. Treatment providers must ascertain whether the child is still actually or potentially being subjected to abusive relationships or circumstances and ally with non-abusive family members and collaborate with protective child welfare agencies.

# ACE Study

One of the largest investigations of childhood abuse and neglect and health and well being in later-life is the CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study.

The original ACE Study was conducted at Kaiser Permanente from 1995 to 1997. There were two waves of data collection. Over 17,000 Health Maintenance Organization members from Southern California received physical exams and completed confidential surveys regarding their childhood experiences and current health status and behaviors.

The ACE study found a high correlation between physical illness later in life and traumatic experiences. The ACE score, a total sum of the different categories of ACEs reported by participants, is used to assess cumulative childhood stress. Study findings repeatedly revealed as the number of ACEs increases, so does the risk for the following:

- risky health behaviors,
- chronic health conditions,
- low life potential, and
- early death.

The CDC continues ongoing surveillance of ACEs by assessing the medical status of the study participants via periodic updates of morbidity and mortality data.

https://www.cdc.gov/violenceprevention/acestudy/about.html

## Trauma-informed care

Understanding the impact of trauma on children is relatively new in the mental health field, and few hospital and residential treatment programs have provided adequate training and supervision for staff members about it. Without specific knowledge about trauma and skills for working with its effects, it is hard to provide trauma-sensitive interventions. For example, interventions that punish aggressive behavior resulting from traumatic triggering often exacerbate a child's trauma symptoms, because the punishment triggers more sympathetic activation and can result in more aggression and/or hypervigilance.

In the past twenty years, treatment providers and researchers have begun to more fully understand how trauma affects people on many different levels. Trauma-informed care is the provision of treatment that recognizes the consequences of trauma for children and offers interventions that address both the behavior or symptom and its underlying post-traumatic cause. It is an emerging practice that can dramatically improve the prognosis for traumatized children in mental health treatment settings. Trauma-informed care principles have been developed by synthesizing current research on trauma, what is known about effective treatment practice, input from trauma survivors, and by differentiating re-traumatizing and strength-based interventions. A strength-based perspective assumes that maladaptive behavior arises in a context where that

behavior was once adaptive. For example, a child's aggressive behavior developed at a time where he/she lived in a violent neighborhood, he/she was neglected, and he/she witnessed his/her mother being beaten. In fact, these behaviors, when understood contextually, are actually "valiant attempts" to cope (Bloom, 2002).

Trauma-informed care systems share key principles with strength-based philosophies, including (NETI, 2006):

- Recognizing that children who have been neglected, experienced significant loss, witnessed violence, or been physically or sexually abused are likely to suffer from severe behavioral problems representing symptoms and memories of the trauma;
- Conducting routine and thoughtful trauma assessments is essential to treating traumatized and neglected children;
- Identifying treatment setting variables and program practices that are inherently re-traumatizing and will therefore exacerbate the symptoms even if the behaviors are controlled;
- Acknowledging that all program staff must be trained to work with traumatized children and provided with ongoing training and supervision on assessment and treatment;

- Valuing and involving the child and family in all aspects of care and creating opportunities for control or mastery for children who have experienced the overwhelming loss of control;
- Using neutral and supportive language because most physical and sexual abuse is accompanied by verbal abuse and the use of neutral language ensures that symptoms will not be excessively triggered in program settings;
- Using neutral and supportive language that does not blame or excessively pathologize the child;
- Creating personalized and flexible plans for each child in the program ensures that the trauma symptoms and behaviors are being addressed proactively (see *Safety Tools* chapter of the *Resource Guide* for more information);
- Providing training for staff members that teaches them to use mindfulness skills to increase their ability to observe, stand back, and collect information rather than reacting immediately to children's behavior and symptoms;
- Supervising staff members to help them refrain from behavior and interactions that might be construed as coercive or controlling by children, families, and other staff members, such as using a sarcastic tone of voice, joking about the children, arguing, making threats, being critical or taking away privileges unnecessarily.

## Programmatic approaches to trauma-informed care

Implementing a trauma-informed treatment model requires organizational commitment at all levels. It is important to provide staff members with the training and resources to conduct thorough trauma assessments, to provide appropriate treatment, and to avoid re-traumatizing practices within the program. Commitment to trauma-informed care requires appropriate training of key administrators and staff members in trauma-specific treatment and resources for systems modifications and performance improvement processes. Depending on the setting, program cultures may require significant changes, because trauma-informed care models minimize the use of coercion and control by emphasizing prevention, articulating de-escalation preferences, and using Safety Tools.

Programs that embrace trauma-informed care practices promote partnerships between staff members and children, rather than labeling children as manipulative, needy, or attention seeking, and value collaboration over compliance. In addition, programs that are trauma-sensitive tend to have lower rates of S/R than programs that use more coercive treatment interventions. Interventions that are more authoritarian may or may not achieve more behavioral compliance in the short term but run the risk of exacerbating trauma symptoms in the long run and interfering with internal skill development.

Not only is commitment to understanding the role of trauma crucial for the successful implementation of trauma-informed care but also commitment to the avoidance of practices that exacerbate trauma symptoms and can be re-traumatizing for the children that staff are trying to help. Unfortunately, our bodies and nervous systems cannot differentiate between an adrenaline response evoked by something currently dangerous and an adrenaline response triggered by some small trauma-related cue. For example, a number of frequently occurring environmental variables found in most child settings involve stimuli that can be very traumatically activating for children: arbitrary or unexpected exercise of authority, lack of choice, humiliation, directly or indirectly being labeled “bad,” being pressured to disclose feelings, being the center of attention (or *not* being the center of attention), isolation, groups of people, having to make eye contact, punishment, raised voices or angry expressions, kind or caring gestures, S/R, and time-out procedures.

Depending on whether the child’s experiences have included more neglect compared to abuse or more abuse compared to neglect, one child may be more easily triggered by threat cues and another by neglect cues. A child with a history of being locked in a closet would likely find the experience of seclusion reactivating and devastating. A child who was held down and sexually abused might find physical restraint terrifying and overwhelming, reminiscent of the experience of an adult holding and hurting him/her. If the child grew up in a large family, groups may be more triggering; if the child grew up in

isolation, being alone may be more intolerable. If the child's exposure was to physical violence, loud voices and sudden movements might be triggering.

## A Case Example

Andrew is a 12 year old boy admitted to a residential program for a variety of behavioral and emotional problems: aggressive acting out at school, sexualized play with a younger sister, explosive outbursts at home, hitting and biting himself, and difficulty in relationships with both peers and adults. The program staff found him extremely difficult even in his initial intake interview. Andrew became agitated in response to questions and attempted to run out of the room and assault other residents, resulting in a staff member having to restrain him. Staff members experienced him as "manipulative," "cold and uncaring," "having no respect for authority," and "scary."

In addition, Andrew responded poorly to attempts by staff to connect to him in a positive way, acting out in response to praise and seeming to sabotage himself each time he began to do better, which led to staff members becoming frustrated and avoiding him altogether. Lost in his treatment was the history with which he came to the program: severe neglect in early infancy by his drug-addicted mother, sexual abuse by at least one of her boyfriends, and physical tormenting by his two older brothers.

As the staff were helped to connect this history to Andrew's behavior, it became clearer that his "cold and uncaring" and "scary" behavior represented fear and emotional withdrawal, an adaptive response to his childhood environment; the lack of respect for authority stemmed from fight/flight responses that were triggered each time he was arbitrarily told to do something; his difficulty with praise and success reflected the experience of having been "groomed" for the sexual abuse with positive attention and gifts.

As staff responded to Andrew by positively re-framing his symptoms ("Of course, you aren't sure you can trust us," "Wow, you sure are good at hiding your feelings when you are upset—you must have had a lot of practice"), using language and tone of voice that signaled calm instead of authority, providing psychoeducation appropriate to his age, and giving him opportunities to contribute input on his behavior plan, Andrew began to exhibit fewer outbursts and an improved ability to regulate his reactions to stimuli.

In the previous example, Andrew's acting out behavior could be tracked to particular trauma-related cues: feeling "trapped" (triggered by any type of confrontation with staff or even in routine meetings), feeling vulnerable (triggered by intimacy, by being treated kindly, attempts to connect with him, being asked to disclose feelings), feeling "bad" or "wrong" (triggered by understandable staff or peer reactions to his behavior).

Even though some triggering is inevitable despite the best, most informed care, the staff's acknowledgement of the role of triggering can be helpful in increasing the child's level of awareness and control over future reactivity. If reactive behavior is labeled as "triggered," even if the child is held responsible for it, then self-awareness and compassion can be facilitated, decreasing the likelihood of the reactivity occurring again or occurring at the same level again.

For Andrew, this intervention entailed reminding him that talking to staff about his behavior did not mean he was trapped, that he could leave and come back if he needed to, as well as reassuring him that being asked to take responsibility for his behavior did not mean he was "bad," and reminding him that it was triggering for him to have to talk about his reactions. Last but not least, staff made an effort to connect with him in a way that was friendly but reserved to decrease the relational triggering and to avoid asking him to be directly vulnerable, while also acknowledging that, of course, he might have some strong feelings.

**The National Child Traumatic Stress Network (NCTSN*)*** is an organization dedicated to raising the standard of care and improving access to services for traumatized children, their families, and communities throughout the United States. NCTSN develops and disseminates effective, evidence-based treatments, collects data for systematic study, and helps to educate professionals and the public about the impact of trauma on children. NCTSN provides information on current empirically supported treatments and promising practices for treating traumatized children (www.nctsn.org).

## Principles of trauma-informed care

Implementation of the following suggestions will pave the way toward more effective, trauma sensitive care in inpatient and residential settings (Hodas, 2006; NETI, 2006).

Where possible, staff members should be given the opportunity to visit programs that have successfully developed and implemented trauma-informed care practices to observe how the practices actually work.

- The first step in implementing trauma-sensitive programming is to review the **organization's mission and values** and reframe them to emphasize the importance of trauma-informed care and to ensure that all components of the program support a trauma-sensitive focus.

- Each treatment program should have a written **philosophy of care** that incorporates trauma sensitivity and spells out how it is integrated into all aspects of the child's daily routine and treatment. Appropriate trauma-sensitive practices must be incorporated into group programming and milieu activities.
- Programs should provide on-going **training for all staff** members in childhood trauma, trauma-informed care, and trauma treatment models. Use of role play and other experiential techniques can increase understanding of the "emotional logic" of apparently illogical, unsafe behavior.
- It is particularly important for all staff members to be trained in how to conduct **trauma assessments.** Consultation and training by trauma experts can help clinicians to be trained to conduct assessments based on verbal reports from the child, verbal reports from non-offending parents and caregivers, treatment records, and information from the child's drawings and play.

- In addition, training on translating assessments into **treatment planning** is equally important. Although problematic and risk-taking behaviors are characteristic in traumatized children, good training and supervision can help staff members intervene in ways that support treatment of trauma symptoms rather than simply responding to the behavior. Programs should strive to provide treatment planning and interventions that resolve behavioral problems and address the underlying trauma issues.
- Specific **modalities** can enhance the effectiveness of trauma-informed care, such as the use of comfort rooms and sensory interventions, caring relationships, positive adult and peer role models, self-esteem building activities, and activities that develop specific skills. Please see the chapter on *Sensory Approaches* and the section on *The Importance of Physical Environment* in the *Resource Guide* for more detailed information on sensory strategies and comfort rooms.

- Given that trauma represents a failure of safety for children, it is especially important that trauma-informed care includes the development of **Safety Tools** specific to a particular program population. An awareness of each child's personal triggers, early warning signs, and an ability to teach a child to recognize his/her triggers and symptoms provides a repertoire of coping skills to effectively manage the feelings that arise. Please refer to the *Safety Tools* section of the *Resource Guide* for several sample Safety Tools.
- Sensitivity to children's histories of trauma and neglect as manifested in the use of respectful and therapeutic **communication strategies**, such as active listening or contextualizing acting out behavior. (For example, listening empathically to a child's excuses for a mistake, rather than immediately correcting him, or reassuring a child with a history of physical abuse that his mistake or acting out will not result in physical punishment.)

- Despite good intentions and policies, hospital and residential programs for children with trauma histories will still inevitably expose children and staff to upsetting incidents. It is important to have a comprehensive **debriefing** procedure in place to use after these incidents that includes specific protocols for how to address the needs of any children and staff members who were traumatized or re-traumatized by the incident. Meticulous reviews of these events can provide information that leads to learning and change and prevention of further re-traumatization.

## Seclusion/restraint (S/R) and trauma

Although S/R techniques have been used routinely for decades in residential and inpatient settings, trauma experts tell us that the use of S/R and other control-oriented treatment practices is re-traumatizing for both children and adults. Trauma treatment and research experience both testify to the importance of avoiding re-traumatization as a first priority in treatment. Although triggering of traumatic activation cannot be completely avoided, as discussed above, it must be kept to a minimum in order to avoid the reactivation of trauma-related symptoms. It is impossible for programs to meet the treatment needs of these children without attention to trauma-informed practices that provide the highest standard of care. There are a number of trauma-informed care practices that have been well researched, and they have been found to support trauma

recovery and symptom improvement and to reduce the frequency of inappropriate child behaviors. Please see the *Promising Practices* chapter in this *Resource Guide* for more details.

Use of trauma-informed care practices in residential and inpatient treatment programs have been reported to result in a number of positive outcomes, such as:

- Staff members make every effort to prevent the use of S/R
- Staff members understand the complex bio-psychosocial and developmental impact of trauma
- Staff members are less likely to respond punitively or be judgmental in response to difficult behaviors
- Staff members are able to respond early to potentially problematic behaviors so that children gain internal controls and the program environment feels safer
- The tone of the milieu is quiet, calm, positive, and respectful, and the program is an appealing place for staff members and children
- Children, families, and staff members are more satisfied with the quality of the care provided at the program
- Behavioral incidents are avoided by using calming and collaborative approaches with children, such as collaborative problem solving, de-escalation strategies, conflict resolution, negotiation, and offering choices.

- The children and staff gain greater understanding of how behavior relates to trauma experience
- There are fewer assaults on staff members and fewer injuries of children and staff members (LeBel & Goldstein, 2005)
- Staff understand their own trauma reactions and vulnerabilities
- Rates of staff turnover are lower and morale is higher (LeBel & Goldstein, 2005).

## Providing care for staff members

Vicarious re-traumatization is the term used to describe a staff member's individualized process of internal change as a result of working with traumatized children, and it includes a number of feelings and subsequent mechanisms for coping with these feelings. "Vicarious re-traumatization is an inescapable effect of trauma—an inevitable hazard of working with trauma survivors." (Saakvitne et al., 2000)

This secondary traumatization results not only from exposure to the details of traumatic experiences but also from the experience of fear and helplessness in the face of trauma-related dysregulation and risky behavior.

When feelings of anxiety or stress become overwhelming for the caregiver, vicarious re-traumatization can result, affecting their sense of identity, their beliefs, their ability to feel

connected with others, their sense of safety, their desire for closeness, and their feelings of safety and control.

It is essential for staff members to pay close attention to their needs when working with traumatized children and to develop healthy strategies for ensuring that these needs are met. If staff members have difficulty recognizing the personal toll resulting from the exposure to trauma, they will not be able to see how it affects their responses to the children, such as over-reacting to a child's behavior out of fatigue and frustration, acting out of anger, and using rigid methods of control, including S/R.

Given the incidence of traumatic events in the general populations (60% of men and 51% of women in Kessler et al.'s 1995 study), organizations must be made aware of the reality that many of their own staff members have experienced trauma themselves. Attention to signs of trauma symptoms in staff members should be part of the supervisor's responsibility, and ideally guidelines should be in place to ensure that staff members can access support. Senior psychiatric administrators in trauma-sensitive programs can ensure that staff members are supported in understanding children with trauma symptoms and that they also have support for themselves and a context for their feelings and reactions to the children in their care.

Staff members should be encouraged to take time off, pursue personal interests, and to seek outside assistance, if

necessary, to cope with the stress inherent in working with traumatized children. It is important to provide staff with support to self-reflect and to develop their own self-care strategies. Staff can even develop their own Safety Tools. Supervision and consultation can also be helpful. Senior staff can offer days away for regenerating and renewal that are enjoyable, playful, and fun, such as picnics, softball games, yoga, meditation, and organized potluck meals.

Conceptual understanding of the feelings and reactions engendered by work with highly symptomatic traumatized children increases the ability to stand back and mindfully observe it, rather than react to it, which is a key ingredient in preventing vicarious traumatization.

## Additional resources

The following resources are included at the end of this chapter

- Diagnostic criteria for PTSD (DSM-V, 2013)
- NASMHPD Position Statement on Services and Supports to Trauma Survivors
- The MA DMH monograph Series on Treatment of Individuals with a History of Trauma
- Adverse Childhood Experiences (ACES) Questionnaire/ Finding Your ACE Score

# Post Traumatic Stress Disorder (PTSD)

## Diagnostic Criteria from Diagnostic and Statistical Manual for Mental Disorders, 5th Edition (DSM-V)

**Note:** The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria below.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s)

2. Witnessing, in person, the event(s) as it occurred to others.

3. Leaning that the traumatic event(s) occurred to a close family member of close friend. In cases of actual or threatened death of a family member of friend, the event(s) must have been violent or accidental.

4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains: police officers repeatedly exposed to details of child abuse).

**Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s)

**Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

**Note:** In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

**Note:** In children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situation) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to the other factors such as head injury, alcohol, or drugs).

2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).

3. Persistent, distorted cognition about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or other.

4. Persistent negative emotions (e.g., fear, horror, anger, guilt, or shame).

5. Markedly diminished interest or participation in signification activities.

6. Feelings of detachment or estrangement from others.

7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behaviors and angry outburst (with little or no provocation) typically expressed as verbal or physical aggression towards people or objects.

2. Reckless or self-destructive behavior.

3. Hypervigilance.

4. Exaggerated startle response.

5. Problems with concentration.

6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of substance (e.g., medication, alcohol) or another medical condition.

*Specify* whether:

**With dissociative symptoms:** The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).

2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

**Note:** To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

*Specify* if:

**With delayed expression:** If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

**Posttraumatic Stress Disorder for Children 6 Years and Younger**

A. In children 6 years and younger, exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s)

2. Witnessing, in person, the event(s) as it occurred to others, especially primary caregivers.
**Note:** Witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures.

3. Learning that the traumatic event(s) occurred to a parent or caregiving figure.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

Note: Spontaneous and intrusive memories may not necessarily appear distressing and may be expressed as play reenactment.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
**Note:** It may be possible to ascertain that the frighten content is related to the traumatic event.

3. Dissociative reactions (e.g., flashbacks) in which the child feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Such trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

5. Marked physiological reactions to reminders of the traumatic event(s).

C. One (or more) of the following symptoms, representing either persistent avoidance of stimuli associated with the traumatic event(s) or negative alterations in cognitions and mood associated with the traumatic event(s), must be present, beginning after the event(s) or worsening after the event(s).

**Persistent Avoidance of Stimuli**

1. Avoidance of or efforts to avoid activities, places, or physical reminders that arouse recollections of the traumatic event(s).

2. Avoidance of or efforts to avoid people, conversations, or interpersonal situations that arouse recollections of the traumatic event(s).

**Negative Alterations in Cognitions**

3. Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame, confusion).

4. Markedly diminished interest or participation in significant activities, including constriction of play.

5. Socially withdrawn behavior.

6. Persistent reduction in expression of positive emotions.

D. Alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outburst (with little or no provocation) typically expressed as verbal or physical aggression towards people or objects (including extreme temper tantrums).

2. Hypervigilance.

3. Exaggerated startle response.

4. Problems with concentration.

5. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

E. The duration of the disturbance is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in relationships with parents, siblings, peers, or other caregivers or with school behavior.

G. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition.

*Specify* whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).

2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

**Note:** To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts) or another medical condition (e.g., complex partial seizures).

*Specify* if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

# NASMHPD Position Statement on Services and Supports to Trauma Survivors

The National Association of State Mental Health Program Directors (NASMHPD) recognizes that the psychological effects of violence and trauma in our society are pervasive, highly disabling, yet largely ignored. Recent research indicates that interpersonal violence and trauma, including sexual and/or physical abuse over the lifespan, is widespread, has a major impact on a wide range of social problems, and are costly if not addressed. The threat of terrorism is now a constant source of stress for many Americans and the sequalae to recent terrorist events have affected untold numbers of citizens. NASMHPD believes that responding to the behavioral health care needs of women, men and children who have experienced trauma is crucial to their treatment and recovery and should be a priority of state mental health programs. In addition, the prevention of traumatic experiences is a fundamental value held by NASMHPD and its individual members; state mental health authorities. Toward this goal, it is important to support the implementation of trauma-informed systems and trauma-specific services in our mental health systems and settings.[1]

The experience of violence and trauma can cause neurological damage and can result in serious negative consequences for an individual's health, mental health, self-esteem, potential for misuse of substances and involvement with the criminal justice system. Indeed, trauma survivors can be among the people least well served by the mental health system as they are sometimes referred to as "difficult to treat"--they often have co-occurring mental health and substance use disorders, can be suicidal or self-injuring and are frequent users of emergency and inpatient services.

Trauma is an issue that crosses service systems and requires specialized knowledge, staff training and collaboration among policymakers, providers and survivors**.** Study findings[2] indicate that adults in psychiatric hospitals have experienced high rates of physical and/or sexual abuse, ranging from 43% to 81%. Studies have

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[1] For purposes of this position statement *Trauma and Traumatic Events* will be defined as the personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss and/or the witnessing of violence (Jennings, 2004; NASMHPD, 2003; Moses, Reed, Mazelis & D'Ambrosio, 2003).

*Trauma Informed Care* is defined as care that is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and is informed by knowledge of the prevalence of these experiences in persons who receive mental health services. *Trauma Specific Services* are defined as promising and evidenced based best practices and services that directly address an individual's traumatic experience and sequalae and that facilitate effective recovery for trauma survivors (NASMHPD, 2004).

[2] All statistics cited can be found in *The Damaging Consequences of Violence and Trauma*, compiled by Ann Jennings, Ph.D. NTAC: 2004 and the NASMHPD Curriculum: *Six Core Strategies for the Reduction of Seclusion and Restraint©*, 2004

shown that up to 2/3 of men and women in substance abuse treatment suffer from posttraumatic stress disorder, acute stress disorder or symptoms; and up to 80% of women in prison and jails were victims of sexual and physical abuse. Children are particularly at risk as over 3.9 million adolescents have been victim of serious physical violence and almost 9 million have witnessed an act of serious violence. Adverse childhood experiences are related to health risk behaviors and adult diseases, including heart disease, cancer, chronic lung disease, skeletal fractures and liver disease. Especially significant for behavioral health care service systems are findings by the National Child Traumatic Stress Network and others that have linked serious behavioral problems to the biological, neurological and psychological effects of violence and trauma in childhood. Early abuse is now believed to create a particular vulnerability to hyper-arousal, explosiveness and/or de-personalization that results in ineffective coping strategies and difficult social relationships.

Confounding and complicating the prevalence of trauma in public mental health service recipients is the fact that mental health services themselves are often experienced as traumatic. The use of coercive interventions such as seclusion and restraint, forced involuntary medication practices, and philosophies of care based on control and containment vs. empowerment and choice often cause unintentional re-traumatization in already vulnerable populations.

The New Freedom Commission Report Achieving the Promise: Transforming Mental Health Care In America calls for the promise of community living for everyone and for the transformation of our mental health systems of care to meet shared goals that facilitate recovery and build resiliency. NASMHPD believes that the implementation of systems of care that are trauma informed is a cornerstone in building service systems that do not traumatize or re-traumatize service recipients or the staff that serve them. Recovery based services are sensitive to trauma issues and are never coercive. The concept of universal precautions is quite valuable when identifying and implementing the principles and characteristics of trauma informed systems of care to avoid traumatization and re-traumatization.

A set of criteria for building a trauma-informed mental health system were developed at a NASMHPD-sponsored trauma experts meeting in 2003, and a number of state mental health authorities have begun to address the these issues in the public mental health system. Trauma informed prevention strategies adopted by states and service systems include reducing and eliminating the use of seclusion and restraint; the use of prevention tools such as trauma assessments, identifying risk factors for violence or self harm, safety planning, advance directives; workforce training and development; and the full inclusion of consumers and families in formal and informal roles.

Services for trauma survivors must be based on concepts, policies, and procedures that provide safety, voice and choice, and—like all good care—must be individualized/personalized. Trauma services must focus first and foremost on an

individual's physical and psychological safety. Services to trauma survivors must also be flexible, individualized, culturally competent, promote respect and dignity, and be based on best practices. Recent research indicates that the most effective approaches for supporting recovery from trauma are well-integrated behavioral health services that also reflect the centrality of trauma in the lives and experiences of consumers. [3]

NASMHPD is dedicated to better understanding of the effects of trauma and violence including physical and/or sexual abuse, neglect, terrorism; implementing emerging culturally competent best practices in trauma treatment within the public mental health system; and considering the role of prevention and early intervention programs in decreasing the prevalence of trauma-related behavioral health problems. State mental health authorities are committed to recognizing and responding to the needs of persons with mental illnesses and their families within a cultural and social context. Asking persons who enter mental health systems, at an appropriate time, if they are experiencing or have experienced trauma in their lives is becoming a standard of care. NASMHPD has taken the lead in recognizing that some policies and practices in public and private mental health systems and hospitals, including seclusion and restraint, may unintentionally result in the revictimization of trauma survivors, and therefore need to be changed.

NASMHPD is committed to working with states, consumers/survivors and experienced professionals in the trauma field to explore ways to improve services and supports for the public mental health service recipient inclusive of trauma survivors consistent with the recommendations of the New Freedom Commission Report. These efforts may include, but are not limited to developing and disseminating information and technical assistance on best practices; supporting research as recommended by the field; providing forums for national dialogues on trauma survivors; consistent advocacy in creating trauma informed and recovery based systems of care; including consumers and their families in the planning, design, implementation and monitoring of best and promising practices; and cooperating with other state and national organizations to develop treatment, prevention and education initiatives to address the issue of trauma.

Original Statement passed unanimously by the NASMHPD Membership on 12/7/98.

Revised Position Statement passed unanimously by the NASMHPD Membership on 1/3/2005.

Available online at:
*www.nasmhpd.org/general_files/position_statement/NASMHPD%20TRAUMA%20Positon%20StatementFinal.pdf*

[3] SAMHSA citation (in press)

**The Commonwealth of Massachusetts**

**Department of Mental Health**

**Monograph Series**

# Treatment of Individuals With a History of Trauma

*March 1999*

The National Association of State Mental Health Program Directors (NASMHPD) recently issued a unanimous position statement on services and supports to trauma survivors. NASMHPD acknowledged the psychological impact of violence and trauma and the need for state mental health authorities to be responsive to the unique needs of trauma survivors with mental illness. The NASMHPD position emphasizes that "trauma services must focus first and foremost on an individual's physical and psychological safety. Services to trauma survivors must also be flexible, individualized, culturally competent, and promote respect and dignity."

Statistics regarding the frequency of trauma are disturbing. Prevalence rates for childhood abuse among psychiatric inpatients are significantly higher than the general population. Research suggests that at least half of all women and a substantial number of men treated in psychiatric settings have a history of physical and/or sexual abuse.

In l996, a Department of Mental Health Task Force was convened to make recommendations regarding restraint and seclusion of persons with a history of physical and sexual abuse. As a result, clinical guidelines were issued in 1996 regarding the treatment and care of trauma survivors. DMH regulations 104.CMR 27.12 also specify that staff pay special attention to needs of trauma victims when using restraint and seclusion. Both the guidelines and the regulations were intended to increase awareness, sensitivity and skills needed by clinicians to treat trauma victims. They are intended to provide basic principles and flexible tools that clinicians should integrate into their practices when treating clients with a history of abuse.

Mental health professionals cannot develop appropriate treatment plans or interventions for clients without knowing their history of trauma. For instance, restraint and seclusion can cause retraumatization because of the similarity to prior traumatic experiences. If a history exists, it is important to determine what approaches or strategies would be most helpful to the client in order to avoid the use of restraint and seclusion. If needed, the kind of restraint or seclusion and the gender of the staff who should administer it should be sensitively determined.

The clinical guidelines provide two assessment forms to determine this information--a trauma assessment form and a de-escalation form. The trauma assessment form is designed to gather information about trauma history as part of the client's intake assessment. The de-escalation form gathers information about the client with the goal of reducing agitation and distress. Other measures outlined in the guidelines are designed to be sensitive to the needs of a person in seclusion or restraint, for example, the ability to observe a clock or the ability to find out the time.

DMH is dedicated to being responsive to the needs of adult, child and adolescent clients who have experienced physical and/or sexual abuse. It should be standard practice to ask clients if they have experienced trauma in their lives so that treatment, services and supports which aid, rather than impede, their recovery can be developed. The NASMHPD position statement supports and reinforces the DMH regulations and guidelines.

# Adverse Childhood Experience (ACE) Questionnaire

## Finding your ACE Score ra hbr 10 24 06

**While you were growing up, during your first 18 years of life:**

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   **or**
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   **or**
   **Ever** hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   **or**
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   **or**
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   **or**
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   **Often** pushed, grabbed, slapped, or had something thrown at her?
   **or**
   **Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard?
   **or**
   **Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

**Now add up your "Yes" answers: _____ This is your ACE Score**

# Trauma-Informed Care

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