

TRAUMA INFORMED CARE & YOUTH SUICIDE PREVENTION

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Presentation for 2008
Pennsylvania 2ND Annual
Suicide Prevention Conference

Tuesday, September 9, 2008
Holiday Inn, Grantville, PA

INTRODUCTION

PRELIMINARY COMMENTS

- Initiatives in different fields often not linked.
- Examples of youth suicide prevention and trauma informed care (TIC), two public health initiatives.
- My interest – building bridges between ideas.
- Past trauma an often underlying, unrecognized source of vulnerability to suicidality. High risk factor.
- Linking of suicide and trauma not accidental.

INTRODUCTION

YOUTH WITH SUICIDALITY AND YOUTH SURVIVING TRAUMA: SHARED ELEMENTS

- Youth aren't asked, and youth don't tell.
- Both have a secret, and experience shame.
- Both experience failure & sense of unworthiness.
- Both feel isolated and alone.
- Both feel helpless and hopeless.
- Both have a distorted sense of reality.
- Both have impaired judgment and self-regulation.

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INTRODUCTION

TRAUMA INFORMED CARE

- An organizing principle of care, which seeks to create a context for positive youth development and prevent inadvertent harm & retraumatization to youth
- Relevant to all youth: those doing well in community, those in need of MH treatment, and those already receiving Rx.

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INTRODUCTION

EVIDENCE BASE FOR TIC IN PREVENTION

- Trauma informed care is a relatively new concept.
- An evidence base for TIC in preventing youth suicide is premature.
- In clinical treatment, no research yet comparing “Rx as usual” with “Rx + TIC.”
- Evidence base does exist for TIC reducing need for seclusion and restraint in residential settings.
- TIC also improves milieu morale and staff retention.

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INTRODUCTION

MY BACKGROUND

- Statewide Child Psychiatrist for PA OMHSAS and Children’s Bureau.
- Children’s policy consultant to Bucks County Behavioral Health System.
- Direct care provider in private, not-for-profit children’s agency (Wordsworth Academy).
- Increasing interest in public health approaches to decrease mortality/morbidity and benefit overall communities.

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INTRODUCTION

STRUCTURE OF PRESENTATION

- Basic data on prevalence of youth suicidality.
- Review of framework for youth suicide prevention.
- Pervasiveness of childhood trauma and significance.
- Relevance of trauma informed care, from both clinical and community perspectives.
- Conclusions & discussion.

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THE DATA

PREVALENCE OF SUICIDE AND SUICIDALITY

- Suicide the 3rd leading cause of death, youth 10-19 years (2004, Centers Disease Control & Prevention)
- Suicide rate among 10-14 yr olds doubled since 1980 (US Public Health Service, 1999).
- 8.5% of youth in US made at least one suicide attempt (SA), last 12 months (Kann et al, 1998).
- Child suicidal ideation (SI) highly predictive of SI and SA in adulthood (11 & 7 times more common) (Herba et al, Netherlands, 2007).

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THE DATA

MULTIPLE VS. SINGLE SUICIDE ATTEMPTERS

- Adolescents with a history of multiple suicide attempts have greater frequency of future suicide attempts than single attempters (39% vs. 17%).
- So frequency of prior SAs matters.
- So does intent to die at time of SA, and regret at surviving the suicide attempt.
- Greatest risk for single attempters: anxiety disorder, plus desire to die or uncertain (Miranda et al, 2007).

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THE DATA

IMPACT OF BULLYING & VICTIMIZATION ON SAs

- Adolescents victimized by bullying and/or engaging in bullying are at increased risk of suicide attempts.
- Those engaging in both behaviors are at greatest risk (33.3% females, 6.5% males) (Klomek, 2007).
- Girls who bully (28.2%) at greater risk than girls who are victimized (17.1%).
- Victimized boys at greater risk (5.1% vs. 3.8%).
- Girls at risk of SAs even with infrequent bullying (8.1)

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THE DATA

IMPACT OF PRE-ADOLESCENT PHYSICAL ABUSE

- Pre-adolescent physical abuse found to be an independent risk factor for adolescent SAs (Salzinger et al, 2007).
- 21% of adolescents abused as a child made SAs, compared to 4% of controls with no prior abuse.
- Childhood abuse increased risk for SA as adolescent by 5.7-8.1 times.
- One protective factor – parental attachment.

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THE DATA

SAs AMONG YOUTH IN JUVENILE DETENTION

- Nearly 90% of youth in JJ with history of prior trauma
- Conditions of incarceration can exacerbate risk.
- Rate of completed suicide among incarcerated youth 2-4 times higher than among youth in community.
- Study of new detainees in Chicago (Abram, 2008):
- 11% with at least 1 prior SA; 3% with SA, prior 6 mos
- Less than 50% of youth with recent SI had disclosed.
- Youth with depression and anxiety at greatest risk.

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THE DATA

CONSENSUS RISK FACTORS

- Previous suicide attempt.
- History of maltreatment or other violence.
- Death of family member by suicide.
- School problems.
- Psychiatric disorders, especially involving depression, anxiety, and impaired self-regulation.
- Co-occurring MH and substance use disorders.

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THE DATA

CONSENSUS PROTECTIVE FACTORS

- Family connectedness.
- Strong social support networks (community, school, peers).
- Participation in community and religious activities.
- Adult mentors.
- Good social and problem-solving skills.

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THE DATA

YOUTH SUICIDE ATTEMPTERS

- Up to 90% have a treatable psychiatric disorder.
- SA a potential risk among all youth, both genders.
- Some act impulsively (substances may disinhibit).
- Some act as result of premeditation.
- Both factors can be involved with same SA.
- Many SAs are not anticipated at all – surprises.
- TeenScreen findings: 74% of youth considering SA, and 50% that had made a SA, were not known.

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FRAMEWORK FOR PREVENTION

CDC YOUTH SUICIDE PREVENTION PROGRAMS: RESOURCE GUIDE (1992)

- Describes types of prevention programs.
- Describes common elements of programs.
- Recommends use of other approaches not necessarily linked to suicide prevention.

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FRAMEWORK FOR PREVENTION

EIGHT TYPES OF PREVENTION PROGRAMS

- School gatekeeper approach – school staff.
- Community gatekeeper approach – community.
- General suicide education – for students.
- Screening programs – for entire group, school.
- Peer support programs – in school or community.
- Crisis centers/Hotlines – in community, emergency.
- Means restriction – limiting access to lethal means.
- Postvention.

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FRAMEWORK FOR PREVENTION

COMMON ELEMENTS, PREVENTION PROGRAMS

- Strategies to enhance recognition and referral of suicidal youth.
- Strategies that address known or suspected risk factors for youth suicide.
- “Certain potentially effective programs targeted at high risk youth are not thought of as ‘youth suicide prevention’ programs.” If an approach addresses “risk factors for suicide,” then it becomes relevant.

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FRAMEWORK FOR PREVENTION

TRAUMA INFORMED CARE IN CONTEXT

- Not a substitute for more specific youth suicide prevention efforts, especially screening.
- TIC as an additional dimension, to decrease vulnerability of designated youth cohorts:
 - Primary (“universal”) prevention – for all youth in normative settings.
 - Secondary (“selective”) prevention – for at-risk youth, in normative and group settings.
 - Tertiary (“indicated”) prevention – for youth in need of specific MH services and levels of care.

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CHILDHOOD TRAUMA

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.

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CHILDHOOD TRAUMA

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).
- Posttraumatic Stress Disorder = re-experiencing, avoidance/numbing, hyperarousal.

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CHILDHOOD TRAUMA

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.

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CHILDHOOD TRAUMA

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

Parallel to youth risk for suicidality

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CHILDHOOD TRAUMA

ADVERSE CHILD EXPERIENCES (ACE) STUDY

- Kaiser Permanente, California, starting in 1995.
- Middle class population; ongoing longitudinal study.
- Goal: to determine relationship between adverse child experiences (“exposures”) – childhood maltreatment & family stress – and later outcomes.
- Outcomes tracked for adults and youth.
- Notable: 50% of adults surveyed reported at least 1 exposure, and 25% reported two or more.

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CHILDHOOD TRAUMA

KEY FINDINGS OF THE ACE STUDY

- A graded relationship between number of categories of exposure (ACE score) and negative outcomes, as adult. Higher score = more impairment.
- Negative adult 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).

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CHILDHOOD TRAUMA

ACE STUDY: DEPRESSION & SUICIDE ATTEMPTS

- Adults with an ACE score of 4 or more: 460% more likely to have depression, compared to score of 0.
- Less than 2% of adults with an ACE score of 0 attempted suicide.
- Nearly 20% of adults with score of 4+ made a SA.
- ACE score of 7+: SA is 30x more likely, as adult.
- ACE score of 7+: SA is 51x more likely, as youth.

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CHILDHOOD TRAUMA

PREVALENCE OF TRAUMA IN US

General population: 61% of men & 51% of women = at least 1 traumatic event (NI. Comorbidity Study).

Males in Detroit: 90% lifetime exposure; 5.3 events.

Public MH clients: 90%; most multiple exposures.

Adolescents in an inpatient psychiatric hospital: 93% reported a history of trauma. 32%, PTSD.

Los Angeles County: 88-91% of students exposed to community violence, most multiple exposures.

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CHILDHOOD TRAUMA

WITNESSING DOMESTIC VIOLENCE IN URBAN SETTINGS

-New Orleans (1990's): 90% of children witnessed violence.

-Boston (1990's), children under age 6: 47% heard gunshots; 10% witnessed knifing or shooting (Groves, Children Who See Too Much, 2002)

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CHILDHOOD TRAUMA

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.

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CHILDHOOD TRAUMA

FEMALES IN JJ – TRAUMA EXPOSURE

- 1ST study: Over 75% of adjudicated females reported sexual abuse.
- 2ND study: Over 90% of incarcerated females reported childhood maltreatment.

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CHILDHOOD TRAUMA

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.

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CHILDHOOD TRAUMA

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.

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CHILDHOOD TRAUMA

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.

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CHILDHOOD TRAUMA

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.

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CHILDHOOD TRAUMA

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.

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CHILDHOOD TRAUMA

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.

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CHILDHOOD TRAUMA

CORRELATES FOR HIGH SUICIDE RISK AMONG YOUTH WITH TRAUMA EXPOSURE

- Recurrent mood disorder.
- Co-occurring mood and substance use disorder.
- Previous suicide attempt.
- Female gender (but this does not preclude males).
- Personality disorder.
- PTSD.

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CHILDHOOD TRAUMA

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.

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CHILDHOOD TRAUMA

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.

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CHILDHOOD TRAUMA

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 noradrenalin – and hypothalamic pituitary axis.

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CHILDHOOD TRAUMA

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.

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CHILDHOOD TRAUMA

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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CHILDHOOD TRAUMA

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).
[Reference: Psychiatric Times, Vol. XVI, No. 9, 1999].

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CHILDHOOD TRAUMA

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.

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CHILDHOOD TRAUMA

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.

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CHILDHOOD TRAUMA

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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CHILDHOOD TRAUMA

YOUTH PRESENTATION (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.

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CHILDHOOD TRAUMA

YOUTH PRESENTATION (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 suicide or accidental death.

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CHILDHOOD TRAUMA

YOUTH ARE OFTEN MISUNDERSTOOD

- By self: Not understand own behavior.
- By parents: Infer intentionality.
- By professionals: Responses can exacerbate the problem.
- Frequent inference: Youth seen as “bad” or unworthy
- Link to suicidality: youth are misunderstood, feel isolated, unworthy, & hopeless.

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TRAUMA INFORMED CARE

TIC BUILDS ON WHAT WE KNOW ABOUT YOUTH & HUMAN NATURE

- Individuals, and youth in particular, respond best to encouragement & respect.
- Humiliation and shaming are counter-productive. Threats by others produce defiance or violence by youth (“law of psychological gravity”).
- James Gilligan: “The purpose of violence is to force respect from other people.”

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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

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TRAUMA INFORMED CARE

ELABORATION OF “TRAUMA INFORMED SERVICES” (Ann Jennings, 2004)

“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...

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TRAUMA INFORMED CARE

PRINCIPLE OF “UNIVERSAL PRECAUTIONS” AS APPLIED TO TIC (Hodas 2005)

- Need to presume that each person has experienced trauma and therefore should receive TIC.
- Principle based on near-universal prevalence of trauma within the population.
- Based also on individual and societal benefits of provision of TIC.

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TRAUMA INFORMED CARE

ANN JENNINGS: KEY ELEMENTS OF TIC

- Services and settings accept & accommodate the vulnerabilities of trauma survivors.
- Inadvertent re-traumatization is avoided.
- Participation & empowerment are promoted.
- Close, collaborative relationships are developed among all involved systems.

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TRAUMA INFORMED CARE

TIC: SYNERGISTIC WITH POTENTIAL FOR CONTINUING NEURAL DEVELOPMENT

- 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 & adaptability.

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TRAUMA INFORMED CARE

MULTIPLE IMPACT OF TIC CARE FOR YOUTH WITH SIGNIFICANT CLINICAL NEEDS

- Harm reduction (avoiding restraints & coercion).
- Medical level (addressing neurobiology & symptoms).
- Rehabilitation level (promoting skills & functioning)
- Recovery level (promoting choices & meaning in life)

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TRAUMA INFORMED CARE

TIC OPERATES AT TWO INDIVIDUAL LEVELS

- 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.

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TRAUMA INFORMED CARE

KEY CHARACTERISTICS OF TIC FOR YOUTH WITH SIGNIFICANT CLINICAL NEEDS

- Can be implemented without need for highly specialized MH expertise.
- Applicable to any level of care or setting.
- Encompasses both prevention of crisis and crisis intervention,
- Avoids re-traumatization.
- Benefits both individuals and groups.
- TIC as “value added,” not a stand-alone approach.

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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.

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TRAUMA INFORMED CARE

SELECTIVE MODELS AND COMPONENTS OF TIC

- “ARC” – National Child Traumatic Stress Network
Attachments - Regulatory capacity – Competencies
- “SELF” – Sanctuary Model (Bloom)
Safety - Emotions - Loss - Future
- Community Connections – (Fallot)
Safety - Trustworthiness - Choice – Collaboration –
Empowerment

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TRAUMA INFORMED CARE

IMPLEMENTING TRAUMA INFORMED CARE

- Trauma informed beliefs
- Trauma informed practices

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TRAUMA INFORMED CARE

TRAUMA INFORMED BELIEFS

- Youth often feel out of control, but don't say it.
- The core consideration involves *avoidance of shame and humiliation*, and avoidance of power struggles.
- Youth need trusting relationships.
- Youth need information for self-awareness & goals.
- Youth need to develop more effective coping skills.
- Youth need support in regaining hope.

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TRAUMA INFORMED CARE

TRAUMA INFORMED PRACTICES (1)

- Address any continuing external trauma or danger.
- Actively engage and build the relationship.
- Be welcoming and non-judgmental.
- Build on youth and family strengths.
- Be a role model for appropriate behavior,
- Obtain a trauma history and a treatment history.
- Anticipate needs, and intervene early.

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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.

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TRAUMA INFORMED CARE

TRAUMA INFORMED PRACTICES (3)

- Avoid intimidation, coercion, and violence.
- Provide ongoing support and encouragement.
- Use self to redirect and de-escalate.
- Focus on “what you went through,” not “what’s wrong with you.”
- Approach “failures” as opportunity for new learning.

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TRAUMA INFORMED CARE

TIC TOOLS AND STRATEGIES

- Trauma history and trauma screening
- Risk assessment for suicidality and violence
- Risk assessment for use of restraint
- *Safety plan (discussed in this presentation)
- Workforce hiring, orientation, training, supervision
- Use of data

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TRAUMA INFORMED CARE

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 do.
- What youth wants to be encouraged to do.
- Identification of others who can provide support.
- Collaborative development of safety plan, part of Rx.

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TRAUMA INFORMED CARE

TRAUMA INFORMED SYSTEMS

- Concept applies to all service systems, schools, and community institutions and organizations.
- TI systems provide safety to all involved members.
- TI systems avoid traumatization and retraumatization of members.
- Through implementation of TI practices, TI systems also reduce community trauma & violence, with potential for meaningful societal change.

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TRAUMA INFORMED CARE

TIC IN THE COMMUNITY – PRIMARY PREVENTION

- Trauma informed human service and educational systems seek to welcome, understand, and empower youth.
- Support youth learning and initiative, rather than confronting, humiliating, and punishing.
- Promote community awareness/acceptance of youth vulnerabilities and risk, and identify resources.
- Promote shifts in male socialization practices.

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TRAUMA INFORMED CARE

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 Geoffrey Canada, Joe Ehrmann, and others.

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TRAUMA INFORMED CARE

GEOFFREY CANADA (1998: *Reaching Up for Manhood: Transforming the Lives of Boys in America*. Boston: Beacon Press)

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TRAUMA INFORMED CARE

CANADA ON DISTORTED MALE SOCIALIZATION

More and more I have become concerned with what boys think they should be, with what they believe it means to be a man. Our beliefs about maleness, the mythology that surrounds being male, have led many boys to ruin. The image of male as strong is mixed with the image of male as violent. Male as virile gets confused with male as promiscuous. Male as adventurous equals male as reckless (pp. vii-viii).

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TRAUMA INFORMED CARE

CANADA ON POSITIVE MALE SOCIALIZATION

Boys need a sense of self that is developed through personal accomplishments and hard work. A sense of self that includes the desire to grow into men who are kind, disciplined, and caring (p. 31).

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TRAUMA INFORMED CARE

CANADA ON CREATING A TRAUMA INFORMED SCHOOL AT RHEEDLEN

(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 (p. 52).

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TRAUMA INFORMED CARE

JOE EHRMANN'S STORY [Jeffrey Marx (2003): **Season of Life**. NY: Simon & Shuster]

- 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.”
- Concern about traditional masculinity: “We compare, we compete. That’s all we ever do. It leaves most men feeling isolated and alone. And it destroys the concept of community” (p. 73).

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TRAUMA INFORMED CARE

JOE EHRMANN'S EXPECTATIONS OF HIS BOYS

I expect greatness out of you. And the way we measure greatness is the impact you make on other people's lives (p. 48).

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TRAUMA INFORMED CARE

THE SOCIAL CONTRACT BETWEEN EHRMANN & BIFF POGGI WITH GILMAN HS FOOTBALL TEAM

- Coaches: *What is our job?* Most of the boys: *To love us.*
- Coaches: *And what is your job?* Boys: *To love each other* (p. 43).

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TRAUMA INFORMED CARE

“COACHING BOYS INTO MEN” (CBIM): ANOTHER GENDER-BASED INITIATIVE FOR MALE YOUTH

- An initiative of the Family Violence Prevention Fund (FVPF), launched in 2001.
- As of 12/07, used in 35 communities in US, and in 7 countries worldwide, in association with UNICEF.
- Program involves athletic coaches teaching healthy relationship choices, including respect and non-violence toward females, to athletes.
- “Violence never equals strength.”

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TRAUMA INFORMED CARE

“MEN’S TRAUMA RECOVERY & EMPOWERMENT MODEL” (M-TREM)

- A trauma-specific, group-based program for adult males in criminal justice. Not yet used with youth.
- Can be used in MH, D&A, homeless shelters, other.
- Out of the 24 sessions, 11 address gender issues – “male messages, emotions, & relationships.”
- Desired outcomes include: emotional modulation, relational mutuality, and reliable parenting.

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CONCLUSIONS

OUTCOMES OF TRAUMA INFORMED CARE –WHAT TRAUMA INFORMED CARE FEELS LIKE

- The subjective experience of trauma informed care is transformational.
- The transformation involves a shift from previous experiences to a renewed experience.

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CONCLUSIONS

Outcomes of Trauma Informed Care (Hodas)

<u>From</u>	<u>To</u>
• Danger	Safety
• Fear	Security
• Uncertainty	Predictability
• Confusion	Understanding
• Disrespected	Respected

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CONCLUSIONS

Outcomes of Trauma Informed Care (2)

<u>From</u>	<u>To</u>
• Coerced	Able to choose
• Threatened	Reassured
• Rejected	Accepted
• Unequal	Partner

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CONCLUSIONS

Outcomes of Trauma Informed Care (3)

<u>From</u>	<u>To</u>
• Hyperaroused	Calm
• Reactive	Reflective
• Fragmented	Coherent
• Mistrusting	Trusting

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CONCLUSIONS

Outcomes of Trauma Informed Care (4)

<u>From</u>	<u>To</u>
• Fragile	Resilient
• Victim	Survivor
• Isolated	Connected
• Overpowered	Empowered
• Violent	Verbal

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CONCLUSIONS

REDUCING YOUTH SUICIDE – WHY TIC CAN HELP

- Relationships heal & slowly restore hope.
- Collaboration promotes engagement & motivation.
- Self-awareness decreases sense of failure & shame.
- Skill development provides problem-solving tools.
- Neural circuits expand, and changes in neurobiology enhance capacity for self-regulation.
- As life gains meaning, self-efficacy & competence grow (resilience), as does quality of life (recovery).

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