Incorporating Trauma Informed Practice and ACEs into Professional Curricula - a Toolkit

Moving from
"What's wrong with you?"
to
"What happened to you?"

This resource was developed and produced by the Philadelphia ACE Task Force Workforce Development Workgroup, Jeanne Felter, PhD, and Leann Ayers, Annie E. Casey Foundation Fellow Class 4, through grant funding to the Health Federation of Philadelphia by the Annie E. Casey Foundation.

We thank them for their support and acknowledge that the findings and conclusions presented in this report are those of the authors alone, and do not necessarily reflect the opinions of the Foundation.

THE PHILADELPHIA ACE PROJECT

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Background

"ACE studies are as revolutionary as germ theory was for the 19th century"

- Sandra L. Bloom, M.D., National Collaborative on Adverse Childhood Experiences (NCAR) 2013

In spite of the enormous public health implications of the landmark 1998 Adverse Childhood Experience (ACE) Study, it has taken many years for this information to reach health and human services professionals and will take more time for it to be fully integrated into their practice. Driven by the desire to improve health through application of this information, a Philadelphia network of providers developed into the Philadelphia ACE Task (PATF) in 2012. This coalition grew and in 2014, identified key areas that could profoundly expand the impact of the study through incorporation of this information. One of these is the curricula in higher education – a realm that can touch all sectors through the professionals that emerge from each institution.

The Annie E. Casey Foundation provided the opportunity to pursue this work through a grant awarded to The Health Federation of Philadelphia in collaboration with Leann Ayers, Annie E. Casey Foundation Fellow Class 4. The goal of the project was to develop a set of recommendations for the integration of information about the adverse childhood experiences (ACEs) and the impact of trauma on children, youth and families into graduate professional education.

The Health Federation of Philadelphia (HFP) is a public health organization and has been the support organization for the PATF since 2014. Its work encompasses local and national work to build capacity for trauma informed and resilient organizations, systems and communities, including the Multiplying Connections Initiative, National Collaborative on Adversity and Resilience (NCAR), the Community Resilience Cookbook, and the Mobilizing Action for Resilient Communities, (MARC) project.

The Higher Education and Workforce Development Workgroup of the PATF was established to work on this priority. The Workgroup, co-chaired by Jeanne Felter, PhD, Program Director and Associate Professor Community and Trauma Counseling, at Philadelphia University and Suzanne O'Connor, Education Manager at the United Way of Greater Philadelphia and Southern New Jersey, designed this toolkit to aid faculty and teachers in a variety of disciplines, specifically social work, behavioral health (including counseling, therapy, and psychology), medicine, nursing, law, public health, and education, to develop or integrate critical content on adverse childhood experiences and trauma informed practice into new or existing curricula of graduate education programs.

Rationale

Over the past 20 years a convergence of research on neuroscience, epigenetics, adversity and toxic stress has irrefutably demonstrated that exposure to trauma, violence, and unrelenting stress adversely affects the health and well-being of children, youth, adults and communities. This new knowledge, brought to the forefront for many through the 1998 Adverse Childhood Experience (ACE) Study, about the traumatic impact of child maltreatment and other adverse childhood experiences, as well as newly identified means of promoting resilience and recovery for children and families, is slowly being integrated into health and human service practice and policy under the umbrella term "trauma informed practice." In many instances, professionals are being introduced to trauma informed practice through workforce development and continuing education. It is also emerging in some graduate education programs including education, healthcare, behavioral health, social work and law, but it is not routine in any of these sectors. Therefore, too many of our emerging professionals may relate to clients and patients without this knowledge – often using a framework of trying to discover what is wrong with a person rather than starting with a more critical question informed by this knowledge and science of ACEs and trauma informed practice: ***"what has happened to this person?"***

It is our expectation that this toolkit will assist faculty who instruct emerging professionals, especially those who work with vulnerable populations, to integrate and incorporate this new knowledge about early childhood adversity and the impact of trauma into existing courses or assist in developing new courses.

Overview

While communities and their systems are increasingly embracing trauma informed approaches (see stories in the Community Resilience Cookbook, including resiliency and recovery for families and children of all ages, graduate education that prepares new professionals in education, social work, behavioral and public health, nursing, law and medicine has not yet comprehensively incorporated this approach.

The Workforce Development Workgroup of the PATF, comprised substantially of diverse faculty that are currently engaged in teaching this material at either the undergraduate and graduate level, generously guided and informed this work. We determined that our best contribution to the project goal would be the following:

1. Conduct an environmental scan covering the availability of academic ACE and trauma informed courses nationally, and a local scan of courses available in the Philadelphia region, and understand current offerings and gaps.

2. Identify a set of key concepts that guide the integration of ACE, trauma and resilience information into courses rather than create a prescriptive curriculum to support flexible adaptation by the institution and its faculty as a module or seminar that can be incorporated smoothly into existing curricula

3. Identify a set of promising practices and approaches already vetted by members of the Workforce Development Workgroup that can be replicated by others.

4. Conduct pilot training utilizing a proposed training module and assess the impact.

Environmental Scan

Two environmental scans were conducted to examine the current offerings in trauma education both on the national level and in the Philadelphia region. The analysis and list that result are by no means exhaustive or absolute but rather serve as an overview of academic institutions that are taking an interest in trauma, resilience, and ACEs in their programs. A summary of the finding is included below. A full report of the National Environmental Scan and of the Philadelphia Region is located on the PhiladelphiaACES.org website.

Process for Collecting Data

The process for collecting data for both scans incorporated a combination of key informant interviews and questions that would identify existing curricula as well as starting points for a web scan. The Philadelphia ACE Task Force Workforce Development Workgroup identified these disciplines - social work, behavioral health (including counseling, therapy, and psychology), medicine, nursing, law, public health, and education - because these disciplines interact most closely with vulnerable populations and have the most power to provide trauma informed care and cultivate resilience.

Information about educational offerings were found by examining online course catalogs, college and university websites, and syllabi and then drilling down within this content using the search terms “trauma”, “aces”, “resilience”, “abuse”, “neglect” and “adversity”.

Typically, information regarding academic programs was located in the “academics” page of each university website. If information could not be found there, a search was conducted through other parts of a university’s website.

Next, course descriptions that included the key terms were reviewed and Workgroup members used their expertise and discretion to decide whether or not the course was directly related to trauma, ACEs and their effects, and trauma informed practice. This was typically signified by course material regarding the effects of trauma on the life course.

One question this search raised, but as unable to answer, was the extent to which courses

regarding substance abuse, and substance abuse treatment, may incorporate this information.

Due to the Environmental Scan's goal to get a broader view of trauma education, all levels of education programs and all fields were included in the scan for examination. The general search term "trauma" was used to discover content and then examined to see if the content was related to ACEs and resilience research. Those that focused on the psychosocial, health-related, compounding, and/or lifetime effects of trauma were included in the scan.

Information was also gathered via ACEsConnection.com, an online community of trauma informed practice. A public forum was posted asking professionals to comment and email any information on trauma education in the United States, which brought a flood of new knowledge and connections including a connection to the listserv for the American Psychological Association's trauma committee.

Findings from the Environmental Scan

The National Scan included an even mix of universities and colleges from the West, Rocky Mountains, Southwest, Midwest, South, and Northeast areas. The Northeast and the West regions contained the largest concentration of trauma education with the highest concentration of trauma-related education found in California and New York.

Most of the trauma education offered nationally is in the field of psychology, which has the largest number of courses, certificates, concentrations, and programs. This trend was also seen when analyzed by region. Social work has the second highest number of trauma education offerings followed by counseling/therapy, medicine, and education. A smattering of offerings was also found in psychiatry, law, public health, sociology, human services, nursing, policy, and criminology with some interdisciplinary activities that brought together a number of these fields.

The colleges and universities in the Philadelphia region included 29 institutions in the City of Philadelphia and the Philadelphia metropolitan area, which includes areas of Pennsylvania, Delaware, and New Jersey.

In the Philadelphia scan, there are many course offerings in trauma but they are often electives or do not cover the full scope of trauma, resilience, and ACE research and application to practice. Most of these courses center on the trauma of domestic abuse/neglect, natural disasters, or large human-caused events (e.g. genocide, war). More promising, however, the majority of trauma education found in this scan is in the form of tracks, concentrations, or certificates. These types of education tools can prepare practitioners with a full range of information on trauma and its effects.

Three important resources were identified during the environmental scan that informed the process and expanded the range of discoverable information. The first was an article by

Courtois and Gold in the American Psychological Association advocating for the inclusion of psychological trauma in professional curriculums of psychology and other fields that serve affected individuals. The article provided an overview of the history of trauma, its importance in the field of psychology, the need for workforce development around this research in many fields, and the affect this change could have on services. The list of resources provided in the reference list contained links to other researchers, databases, and institutions with similar goals as this environmental scan. The second important resource is a 2013 database of undergraduate and graduate education in trauma psychology that was assembled by the Education and Training Committee of the American Psychological Association (APA). Though some of the information in this database is outdated or not useful to this environmental scan, this provided a foundational list for exploring higher education institutions offering trauma education. The third resource is the TeachTrauma website made by members of Division 56, the division of trauma psychology of the APA. This website provided syllabi for trauma education that has been used by professors in both undergraduate and graduate education, a list of informational websites, and textbook reviews.

The breakdown of the National Environmental Scan's trauma education matrix:

Number of Schools In Region that have Trauma Education Components by Region of Country

Region	Number of Schools
Northeast	16
Southern	11
Midwest	10
West	9
Southwest	5

Number of Trauma Based Programmatic Offerings by Field

Field of Study	Number of Offerings
Social Work	19
Psychology	17
Counseling / Therapy	11
Medicine	8
Education	7
Public Health	4
Nursing	3
Sociology	2
Human Services	2
Criminology	2
Law	2
Psychiatry	1
Policy	1

Level of Trauma Programmatic Offering and Number of Each Type Offered

Level of Trauma Education	Number of Each Level Offered
Courses	17
Research Center / Project	16
Certificate	15
Program	9
Track / Concentration	5
Trauma Informed Practice / Curriculum Design	3
Fellowship / Internship	2
Health Services	2
Workshop	1

Key Concepts and Resources for Courses

Overview of Section

The ACE Study (Felitti & Anda, 1998) and subsequent research has generated a growing awareness that trauma is frequently at the root of social, emotional, and psychological difficulties. Consequently, many individuals, systems and institutions across various human service sectors are seeking and/or providing training in trauma informed service delivery. This section of Key Concepts draws on existing literature and resources, as well as the experience and expertise of individuals involved in this project, to provide recommendations for the requisite content areas that should be addressed in any foundational trauma training.

Existing Models

Following is a brief discussion of existing models or frameworks that support the concepts discussed. It is recommended that individuals who seek to provide trauma trainings, or those who wish to engage in training in order to enhance their own trauma sensitivity or build competencies, delve deeper into these resources, which are also listed in the Appendices.

Dr. Sandra Bloom (The Sanctuary Model, 1994) suggests that being "trauma informed" means that one embraces and demonstrates new mental models informed by trauma theory. The way trauma informed individuals and organizations think about behavior, violence, emotion, learning, communication and growth is deeply impacted by their awareness of the prevalence and pervasiveness of trauma. The authors highly recommend the extensive works of Dr. Bloom and the Sanctuary Institute, especially organizations and systems that seek a theory-based, trauma informed approach to culture change.

Fallot and Harris (2009) offer an important overview of the rationale for trauma informed service approaches, as well as a vision and guide for the change process necessary to shift frameworks and implement a trauma informed approach. The rationale and vision for change are reflected in the concepts discussed in this paper.

Additionally, Bath (2008) provides three critical treatment elements for all individuals who interact with traumatized children as a part of their familial or professional roles. These "Three Pillars" include Safety, Connections, and Managing Emotions and align closely with the recommendations provided.

Lastly, the Missouri Model (2014) provides an organized framework for considering the stages required in the process of becoming trauma informed, as well as the knowledge, attitudes and skills that deepen as an individual, organization or system progresses through the change process. It further provides a comprehensive list of resources that support growth. It should be noted that the training recommendations provided in this paper align

with the first stage in The Missouri Model's progression: Trauma Aware.

The key concepts described below draw on these and other resources, and provide the building blocks for training that aims to raise awareness about the prevalence and impact of trauma, and inspire changes in mental models, or framework shifts, that lead to more compassionate and supportive care for trauma-affected individuals.

The Learning Environment

Trauma, by its very nature, is a difficult topic that frequently inspires emotional reactivity. It is not uncommon for individuals to be deeply impacted by newfound knowledge related to the pervasiveness or impact of trauma, or by related discussions. Further, research supports that the majority of people today have their own lived experience of trauma. Thus, it is expected that many individuals will reflect upon their own lived experiences of trauma or adversity while in the class or shortly thereafter, or that one or more individuals could become emotionally reactive because the content closely relates to their own personal stories. Because of this high potential for reactivity among students, the authors propose the following parameters related to the learning environment within which a course will be delivered in order to encourage safety, emotional regulation and support.

Limit Instructor-to-Student Ratio

We recognize that the goal of many organizations and systems is to educate as many people as possible with few available resources. However, because of the intensity and complexity of this subject matter, as well as the potential for emotional reactivity, the authors recommend a smaller, more intimate setting that promotes safety and limits distractions.

Two instructors, or a primary and an assistant are also better than one. While one person is offering content, the other can attend to the emotional states of those in the room.

Provide Cautions and Disclaimers

Prior to diving into content, it is critical that instructors educate students that they may feel a level of discomfort or distress as a result of the content and discussions. It is also important that students are provided with examples of appropriate and healthy ways to manage emotions if they are feeling reactive (e.g., take a short walk, take a break and journal, connect with any available resource in the room like the additional instructor or other staff members).

Further, students should receive education about appropriate sharing and should be encouraged to maintain boundaries around their stories. Instructors should clearly state the goals of the course and remind students that the course is not intended to provide a venue for personal story telling, or a support or therapy group.

Take Breaks and Allow Time for Check-ins

The authors suggest that the content be broken up into manageable pieces (this Key Concepts section provides a possible framework), and that students are allowed some time between segments to journal or engage in healthy self-care activities.

During breaks, instructors can also attend to any students that are presenting with a concerning level of distress.

Choose Activities Intentionally

Though discomfort and self-reflection are necessary ingredients for cognitive and behavioral change to occur, the classroom space is not always the best venue for these important processes. Consequently, we encourage instructors to be very intentional in their selection of class activities and to ensure that the level of vulnerability expected of students match the level of established safety among group members and within the environment, and the available resources to promote emotion regulation, self care and any necessary follow-up.

Provide Resources for Support or for Ongoing Self-Care

Students should leave the trauma informed course(s) with resources that encourage self-care and support, including possible free or reduced-cost therapists, self assessments related to compassion fatigue and vicarious trauma, available support groups, and self-care ideas/resources. See Concept 4 below for some possible self-care resources.

For each of the established concepts below, the authors provide learning objectives, suggest key discussion topics, include available resources, and provide cautions related to specific content when necessary.

RESOURCES

Texts and Manuscripts

Bath, H. (2008). The three pillars of trauma informed care. Reclaiming Children and Youth, 17-21.

Black, T. (2006). Teaching trauma without traumatizing. Traumatology, 266-71.

Bloom, S.L. (1994). The Sanctuary Model: Developing generic inpatient programs for the treatment of psychological trauma.

Fallott, R.D. and Harris, M. (2009). Creating cultures of trauma informed care (CCTIC): A self-assessment and planning tool.

Felitti and Anda, Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults - The Adverse Childhood Experiences (ACE)

Study, The American Journal of Preventive Medicine, May 1998 Volume 14, Issue 4, Pages 245–258

Lieberman, L. (n.d.). Walking the walk: Modeling trauma informed practice in the training environment.

The Missouri Model- A Developmental Framework for Trauma Informed (2014)

Felitti and Anda, Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults - The Adverse Childhood Experiences (ACE) Study, The American Journal of Preventive Medicine, May 1998 Volume 14, Issue 4, Pages 245–258

Web Resource

The Sanctuary Institute

Presentation Slide Deck with Key Concepts

Following are the Five Key Concepts for a course or module. Each Key Concept includes Learning Objectives, Key Topics, the slide numbers covered and Resources for that concept. In addition, there is guidance on "Cautions," or steps to help sensitively inform the class of potential impact of hearing the information. The slide deck is available in Appendix A.

KEY CONCEPT 1:

The Impact of Adverse Childhood Experiences and Implications for Adulthood (slides 1-5)

It is recommended that trainings that aim to build awareness about trauma begin with an introduction to The Adverse Childhood Experiences (ACE) Study (1998).

Learning Objectives

By the end of this segment students will be able to:

- Describe the ACE Study, including a general discussion of the origins, methods, and findings of the study
- Discuss the limitations of the study, including the lack of diversity among study participants
- Discuss the implications of this research

Topic: Three Essential Components of the ACE Study

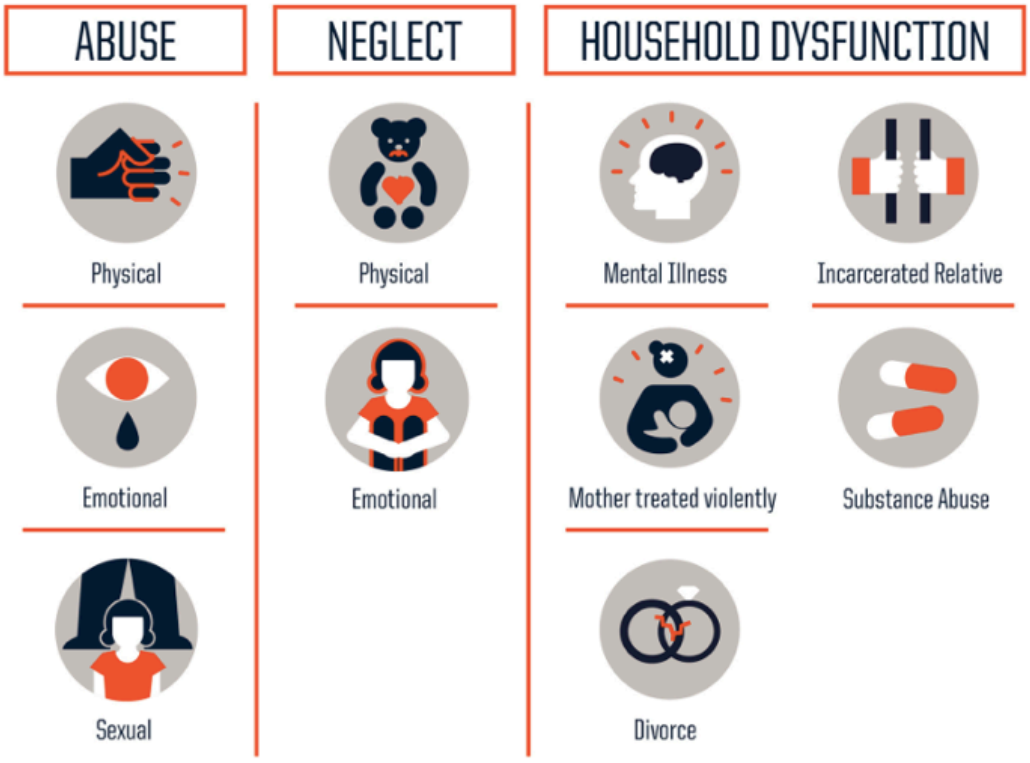
The following should be discussed about the ACE Study:

1. Origins of the ACE Study (slide 1)

- Origins of the ACE Study, including Vincent Felitti's work with obese women and his recognition that the majority of his obese female patients had endured sexual abuse in childhood
- Felitti's eventual partnership with Robert Anda of the CDC

2. Methods and Participants (slides 1,2)

- The largest epidemiological study of its kind
- Calculating ACE Score: provide participants with an overview of how the ACE Score was calculated in the study



Source: Centers for Disease Control and Prevention
Credit: Robert Wood Johnson Foundation

3. Findings (slides 3,4,5)

- ACES are common
- The impact of ACES are pervasive (impact development, physical health, emotional/

social/psychological functioning, genetics, early death)

- Now supported by a growing body of epidemiologic and neuro-scientific research, including data from a more diverse urban sample: the Philadelphia ACE Study

RESOURCES

Web Resources

AcesTooHigh.com

CDC.gov/violenceprevention/acestudy

ACEsTooHigh.com/got-your-ace-score

Philadelphia ACE Study (Philadelphia Expanded ACE, or Urban ACE Study)

Video

Nadine Burke Harris, TEDtalk: How Childhood Trauma Affects Health Across a Life

CAUTIONS

There may be students in the class who have high ACE scores and who interpret the information provided to mean that they are fated to experience negative physical and emotional health outcomes and early death. There may also be parents in the room who have children who have experienced adversity and who then develop a great deal of worry for their children's future. Instructors should consider the students' experiences, the context of the class, and the potential need for follow up support in order to make a thoughtful decision about providing students the opportunity to calculate their own ACE scores. Below are available resources for ACE self-tests.

RESOURCES

Web Resources

NPR- Take the ACE Quiz

Help to frame a positive discussion about ACES. While discussing ACE data, also incorporate resilience data. Note that the overwhelming majority of people who experience a trauma heal on their own without any intervention. Note that compassionate, caring relationships help heal. Note that early and intentional intervention can reduce and reverse the impact of childhood trauma. Note that there are always exceptions - people who have endured a great deal and who are healthy, high functioning, successful adults.

Additional Resources

Texts and Manuscripts

Felitti, V. J., & Anda, R. F. (1998.) The Adverse Childhood Experiences (ACE) study. Centers for Disease Control and Prevention.

Fellitti, Vincent: Turning Gold Into Lead

Videos

How Do We Stop Childhood Adversity from Becoming a Life Sentence. Benjamin Perks, TEDxPodgorica

How childhood trauma affects health across a lifetime, Nadine Burke Harris, TEDMED 2014 · 15:59 · Filmed Sep 2014

Wounds that Won't Heal – The ACE Study, Calvacade Productions, Presented by Robert Anda, M.D., Vincent Felitti, M.D., Bessel van der Kolk, M.D.

KEY CONCEPT 2:

Defining Trauma (slides 6-12)

> *"Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life."*
>
> - Judith Herman, Trauma and Recovery

Courses that aim to bolster awareness of the impact of trauma must support students in their ability to define key terms that are frequently used in the literature, mainstream, and in practice, and should further provide data to underscore the prevalence rates of adversity among children today.

Learning Objectives

By the end of this segment students will be able to:

1. Provide a definition of trauma
2. Differentiate between acute/single incident trauma, chronic traumatic stress and complex trauma
3. Cite statistics that underscore prevalence of childhood trauma

Topic 1: Definitions

As the below graphic from canarratives.org suggests, many terms currently exist to depict the varying categories of adversity, as well as the severity and duration of stress endured in childhood. Putnam et al (2015) suggest that no single term is better than another, and no term can cover the breadth of variety of trauma experienced by children. However, it is important to understand and define a few of the prominent terms, acknowledging that there exists much overlap in definitions.

SAMHSA defines trauma by discussing "**Three E's**," which include:

- An **Event**, series of events, or set of circumstances that is
- **Experienced** by an individual as physically or emotionally harmful or threatening, and
- That has lasting adverse **Effects** on the individual's functioning and physical, social, emotional, or spiritual well-being.

RESOURCES

Web Resources

S. (2014, July). SAMHSA's Concept of Trauma and Guidance for a Trauma informed Approach Prepared by SAMHSA's Trauma and Justice Strategic Initiative.

Complex Trauma. (n.d.).

The National Child Traumatic Stress Network (NCTSN) differentiates **acute trauma** from chronic traumatic stress. According to NCTSN, acute trauma, or single incident trauma, involves:

- Experiencing or witnessing a serious injury
- Facing imminent threats of serious injury or death, or
- Experiencing a violation of personal physical integrity, calling forth overwhelming feelings of terror, horror, or helplessness.

In contrast, **chronic traumatic stress** results from repeated exposure to trauma over long periods of time, calling forth a range of responses including intense feelings of fear, loss of trust in others, decreased sense of personal safety, guilt, and shame.

The term **complex trauma** is used when an individual is both exposed to multiple severe and pervasive traumatic events (i.e., abuse or profound neglect), which are often of an interpersonal nature, and the broad, long-term impact of these exposures, which typically include disrupted development and interfere with the child's ability to form secure attachments.

RESOURCES

Web Resources

Defining Trauma and Child Traumatic Stress. (n.d.).

Complex Trauma. (n.d.).

Regardless of the definition or term utilized, students should have the following basic understandings:

- Trauma is not an event, in and of itself. For an event to be considered traumatic it must involve the individual's perception of the event as severely physically or emotionally threatening, and must impair the individual's functioning. For example, being placed in foster care is only a trauma if the child perceives the disrupted attachment to be overwhelming and frightening. Some children, albeit few, experience great relief when placed in a calm, nurturing foster home, and consequently would not experience the foster care placement as traumatic.
- Trauma is complex and manifests in unique ways in each person impacted by it.
- Trauma, especially chronic or complex trauma of an interpersonal nature is frequently under-reported and under-diagnosed.

Topic 2: Prevalence Rates of Childhood Trauma

This presentation should provide data that underscores the fact that nearly half of our nation's children have experienced one or more traumatic events, and a staggering number of children (over 60% in the past year) witnessed violence in their homes, schools, or communities. The following is a list of online resources that provide specific statistics and important commentary on the data.

RESOURCES

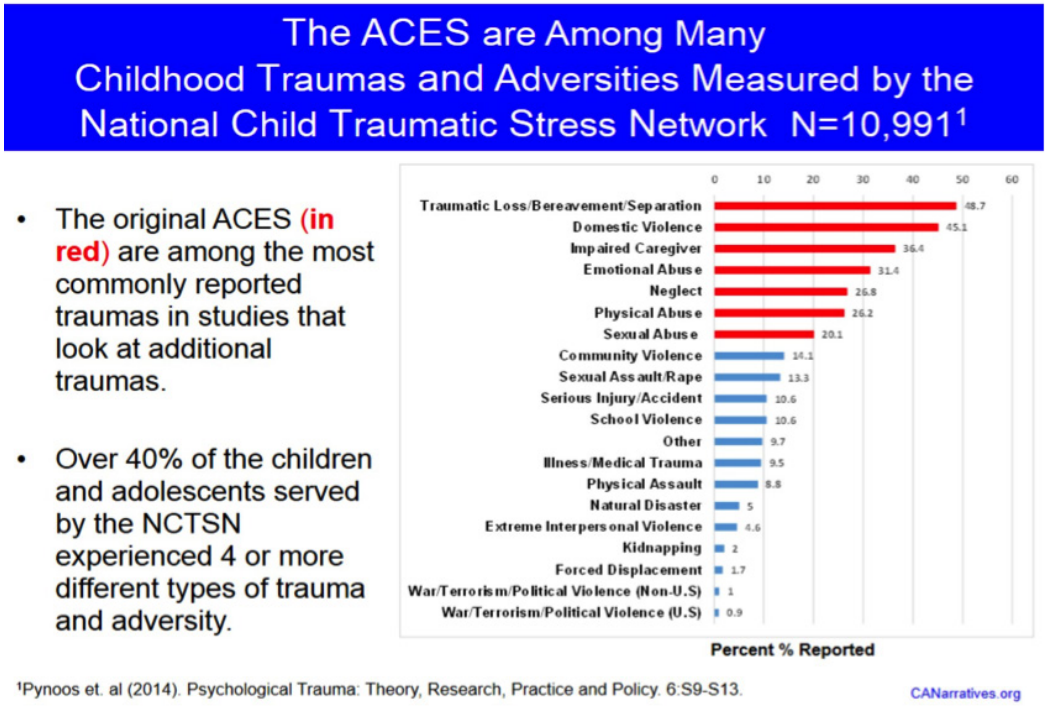
Web Resources

NCTSN Facts and Figures

ACES Too High News

American Psychological Association

Supporting graphic from canarratives.org:



KEY CONCEPT 3:

The Impact of Trauma on Development and Behavior (slides 13-24)

Traumatic events, including experiencing or witnessing violence, abuse, or neglect, often lead to substantial deficits in neurodevelopment, and produce symptoms of dysregulation, hyper-arousal, sensory sensitivity, avoidance, and dissociation in individuals. In particular, children with trauma histories demonstrate deficits in cognition, memory, sensory modulation, and visual processing (Ito, 1999; Koomar, 2009; Richardson, et al., 2015).

Consequently, it is imperative that a foundational training provides an overview of the potential developmental impact of trauma on the child, with a strong focus on neurodevelopment, social development, and cognitive development & learning.

Learning Objectives

By the end of this segment students will be able to:

1. Discuss and demonstrate (using a hand model) the activation of different areas of the brain (specifically the brain stem and limbic system) when faced with fear/danger.
2. Describe the potential impact of trauma on the developing brain.
3. Provide examples of behaviors that align with different brain states.
4. Discuss the potential impact of childhood adversity on social relationships.
5. Discuss the potential impact of childhood adversity on learning and cognition.

Topic 1: The Developing Brain and the Fear Response

A great basic tool for understanding the architecture of the brain can be found in Dan Siegel's Hand Model of the Brain. Instructors are encouraged to discuss the basic brain architecture and highlight how trauma and adversity in childhood, especially complex trauma and chronic stress, can impact the brain's anatomy and biochemistry. The following YouTube video of Dr. Siegel's Hand Model has been found to support instructor and student understanding.

RESOURCES

Videos

Dr Daniel Siegel presenting a Hand Model of the Brain [Video file]. (n.d.).

Dr. Bruce Perry provides many resources to support learning about neurodevelopment. Below are a few readily available resources, but many more are available through the ChildTrauma Academy.

RESOURCES

Perry, B.D. Effects of traumatic events on children.

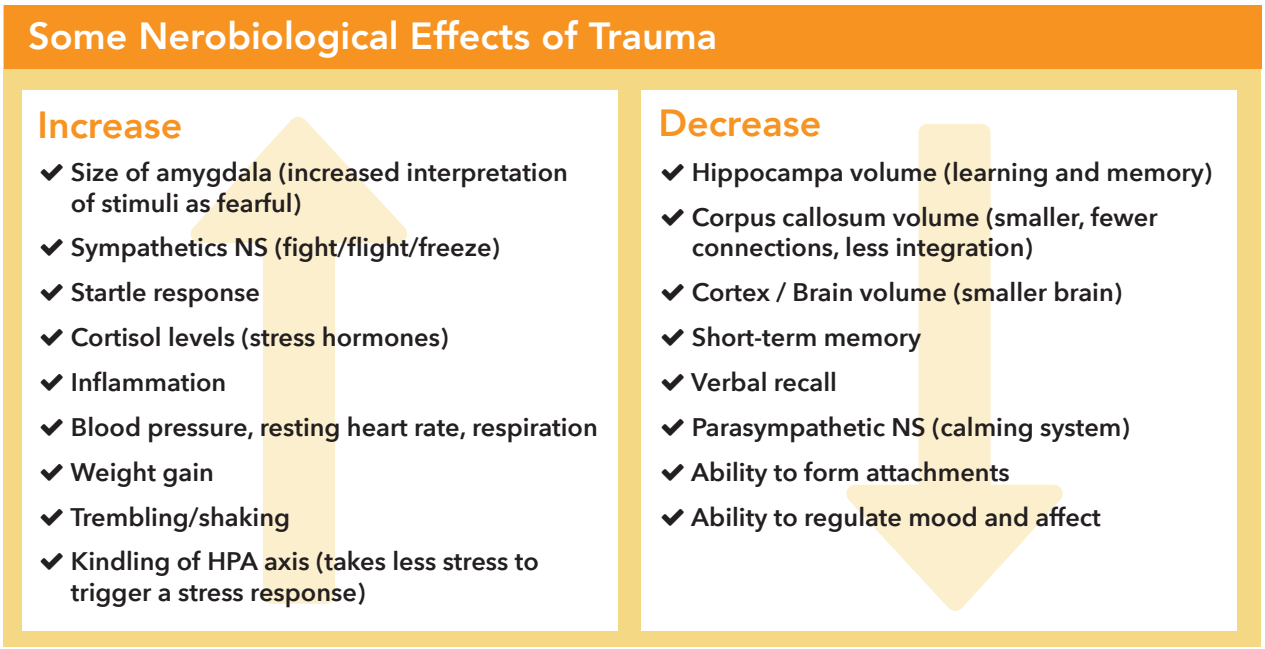
Perry, B.D., (The ChildTrauma Academy). (2013) 1: The Human Brain [Video webcast]. In Seven Slide Series. Core concepts regarding brain structure and function are introduced providing the basis for developmentally sensitive and trauma informed caregiving, education and therapy.

Perry, B.D., (The ChildTrauma Academy). (2013) 3: Threat Response Patterns [Video webcast]. In Seven Slide Series. The variety of adaptive responses that can be used under threat are introduced, with a focus on the hyperarousal and dissociative continuum.

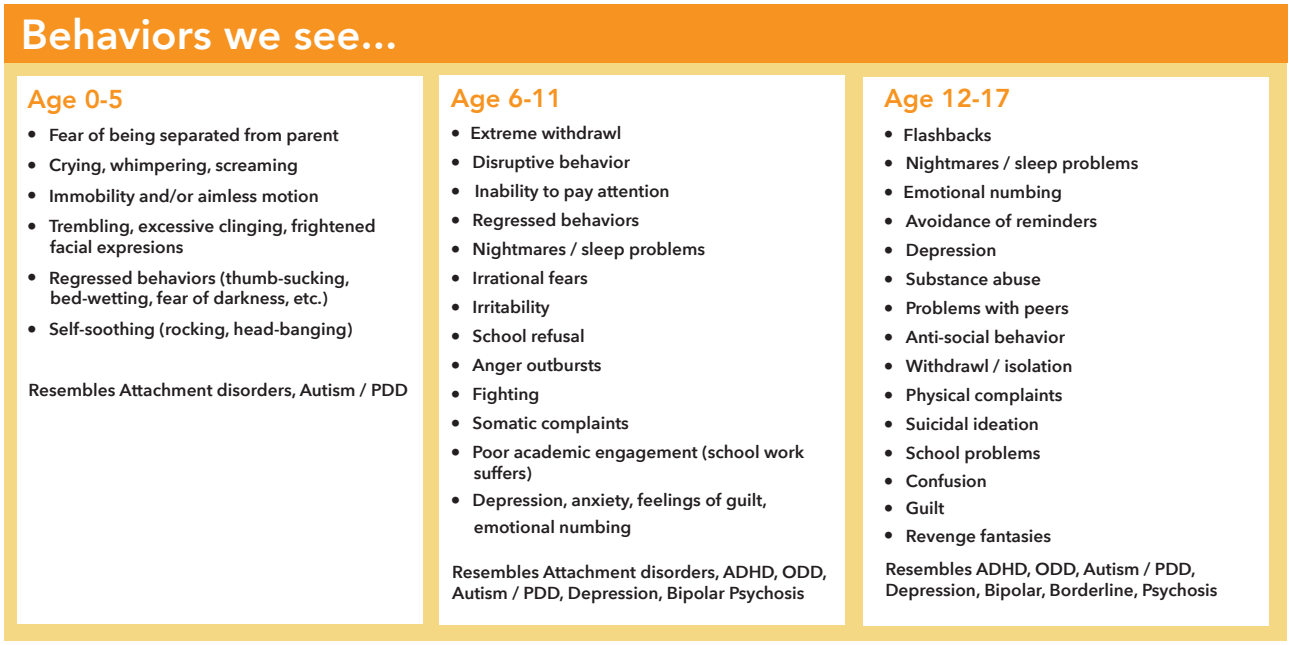
Perry, B.D., How trauma affects child brain development. KUNM, NPR Affiliate (2014) [Radio broadcast] Dr. Bruce Perry talks about his research showing how a child's environment, particularly those who encounter trauma, affects brain development.

Dykema, R. (2006). Don't talk to me now, I'm scanning for danger: How your nervous system sabotages your ability to relate.

Additionally, the following graphics (Felter, 2014) aid in raising awareness of the impact of trauma on the brain's anatomy and biochemistry, as well as the potential behavioral manifestations of trauma at varying developmental stages:



Felter (2014)



Felter (2014)

Topic 2: The Impact of Trauma on Social Relationships

Following is a list of resources that encourage learning related to the impact of trauma on attachment, bonding, and social relationships:

RESOURCES

Serve and Return, The Center on the Developing Child at Harvard University

Perry, B.D. Bonding and attachment in maltreated children: Consequences of emotional neglect in childhood CTA Parent and Caregiver Education Series Volume 1: Issue 3, ChildTrauma Academy Press 1999.

Perry, B.D., (Chicago Idea's Week). (2013) Departures: The Nature of Humankind [Video webcast]

Topic 3: The Impact of Trauma on Learning and Cognition

Following is a list of resources that bolsters an understanding of the impact of trauma on learning and cognition:

RESOURCES

Persistent Fear and Anxiety Can Affect Young Children's Learning and Development

Kamanetz, A. (2014). How trauma affects the brain of a learner.

Additional Resources

Texts and Manuscripts

Gottlieb, Daniel (2014). The Wisdom We're Born With: Restoring Our Faith In Ourselves. New York, NY: Sterling.

Herman, J. (1992). Aftermath of Trauma and Recovery. New York, NY: Basic Books

Ito, Y., Teicher, M.H., Glod, C.A. & Ackerman, E. (1998). Preliminary evidence for aberrant cortical development in abused children: A quantitative EEG study. The Journal of Neuropsychiatry and Clinical Neurosciences, 10(3), 298-307.

Koomar, J. (2009). Trauma and attachment-informed sensory integration assessment and intervention. Sensory Integration Special Interest Section Quarterly, 32(4), 1-4.

Richardson, M., Black-Pond, C., Sloane, M., Atchison, B., Hyter, Y., Henry, J. (2015). Neurodevelopmental impact of child maltreatment. In Clements, P., Seedat, S. & Gibbings, E. N. (Eds.) Mental health issues of child maltreatment. St. Louis: STM Learning, Inc. pp. 13-36.

Web Resources

The Amazing Brain booklet series

Multiplying Connections, Health Federation of Philadelphia

Presentations

Felter, J.M. (2014). Trauma Informed and Responsive Education Part I: The Impact of Childhood Adversity on Learning and Behavior. Part 1 of a Professional Development offered to Faculty, Staff and Administrators at a local elementary school. Souderton, PA: May.

Felter, J.M. (2014). On the Path to Trauma Competency. Professional development presentation provided to paraprofessionals at Resources for Human Development, Philadelphia: February.

KEY CONCEPT 4:

Defining Trauma Informed Care (slides 25-32)

> *"Trauma informed care is an approach to engaging people with histories of trauma that recognize the presence of trauma symptoms and acknowledge the role that trauma has played in their lives."*
>
> -National Center for Trauma Informed Care (NCTIC, 2013)

Learning Objectives

By the end of this segment students will be able to:

1. Provide at least 4 reasons that support the need for trauma informed care in their own discipline or profession
2. Discuss the key features of trauma informed care for their own discipline or profession

Topic 1: Rationale for Trauma Informed Care

Trainings should provide a sound rationale for individuals across disciplines and professions to engage in trauma informed care, highlighting the impact of trauma on the individual and systems, including the following:

- Trauma is pervasive
- The impact of trauma is far-reaching
- Trauma affects how people approach services designed to help them
- Helping services can be inadvertently re-traumatizing

The rationale should also focus on resilience and recovery, highlighting:

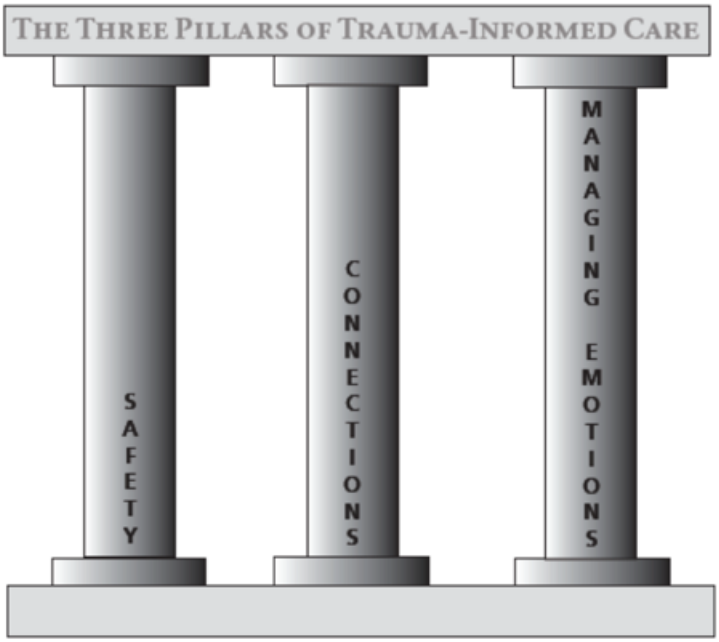
- Recovery and healing are possible (neuroplasticity, neurogenesis)
- Protective factors facilitate healing and resilience
- Healing takes place within the context of safe and supportive relationships

Topic 2: Key Features of Trauma Informed Care

For an introductory training, the authors suggest using Bath's (2008) "Three Pillars" when describing the key features of Trauma Informed Care (citation and link provided below).

For more extensive and advanced trainings specific to mental health treatment, the authors suggest referencing Schnyder et al (2015), in order to highlight the common features of trauma-specific evidenced-based practice, which include:

- Psychoeducation
- Emotion regulation and coping skills
- Imaginal exposure
- Cognitive processing, restructuring, and/or meaning making
- Emotions
- Memory processes



Additional Resources

Texts and Manuscripts

Bath, H. (2008). The three pillars of trauma informed care. Reclaiming Children and Youth, 17-21. Evans, J.K. (2013). What does "trauma informed care" really mean?

Fallott, R.D. and Harris, M. (2009). Creating cultures of trauma informed care (CCTIC): A self-assessment and planning tool.

Schnyder, U. et al. Psychotherapies for PTSD: what do they have in common? European Journal of Psychotraumatology, [S.l.], v. 6, Aug. 2015. ISSN 2000-8066.

Web Resources

NCTSN: Creating Trauma Informed Systems

The Sanctuary Institute

The Sanctuary Model

Child Welfare Information Gateway: Trauma Informed Practice

KEY CONCEPT 5:

Coping with Secondary Exposure to Trauma (slides 33-34)

Individuals who engage empathically in their professional or familial roles with people who have been impacted by trauma are vulnerable to emotional and psychological distress. Every trauma-focused course, regardless of duration and intensity of focus, should underscore the potential impact of this work on the caregiver, and provide supportive resources for helpers to monitor and address their own emotional needs.

Learning Objectives

By the end of this segment students will be able to:

1. Define Secondary Traumatic Stress (STS), Vicarious Trauma (VT), Compassion Fatigue and Burnout
2. Describe the warning signs of STS/VT and identify self-monitoring tools and strategies
3. Identify the ABCs of addressing VT and discuss steps related to each domain that one could take to optimize health and efficacy

Topic 1: Defining Terms

The term Vicarious Trauma (VT) (Perlman & Saakvitne, 1995), also called Compassion Fatigue, is the latest term that describes the phenomenon generally associated with the "cost of caring" for others (Figley, 1982). Other terms used are:

- Secondary Traumatic Stress (STS) (Stemm, 1995, 1997)
- Secondary Victimization (Figley, 1982)

VT should not be confused with "**burnout**". Burnout generally happens over time, and as it builds, making a change like taking time off, diversifying clientele, or a different job, can improve or eliminate burnout. Vicarious trauma, on the other hand, involves the caregiver experiencing trauma symptoms as a result of tension and preoccupation of the stories/trauma experiences described by clients. PTSD-like symptoms that the helper may experience can include avoidance, numbing and hyper-arousal.

The Best Start Resource Center provides the graphic below within their guide for early childhood service providers entitled, "When Compassion Hurts," in which they differentiate between burnout, VT and STS.

Comparing Burnout, Vicarious Trauma and Secondary Trauma

Burnout	Vicarious Trauma, Compassion Fatigue	Secondary Trauma, Indirect Trauma
Cumulative, usually over long period of time	Cumulative with symptoms that are unique to each service provider	Immediate and mirrors client/ patient trauma
Predictable	Less predictable	Less predictable
Work dissatifaction	Life dissatisfaction	Life dissatisfaction
Evident in work environment	Permeates work and home	Permeates work and home
Related to work environment conditions	Related to empathic relationship with multiple client's/patient's trauma experiences	Related to empathic relationship with multiple client's/patient's trauma experiences
Can lead to health problems	Can lead to health problems	Can lead to health problems
Feel under pressure	Feel out of control	Feel out of control
Lack of motivation and/or energy	Symptoms of post-traumatic stress disorder	Symptoms of post-traumatic stress disorder similar to client / patient
No evidence of triggers	May have triggers that are unique to practioner	Often have triggers that are similar to the client's/patient's triggers
Remedy is time away from work (vacation, stress leave) to recharge or positive change in work environment (this might mean a new job)	Remedy is treatment of self, similar to trauma treatment	Remedy is treatment of self, similar to trauma treatment

Dr. Laurie Pearlman introduces one additional term, Vicarious Transformation, which is the process in which one intentionally seeks to transform Vicarious Trauma in a positive way. Pearlman offers 3 strategies that promote this process including:

- Engaging deeply
- Expanding our Resources
- Examining our Beliefs

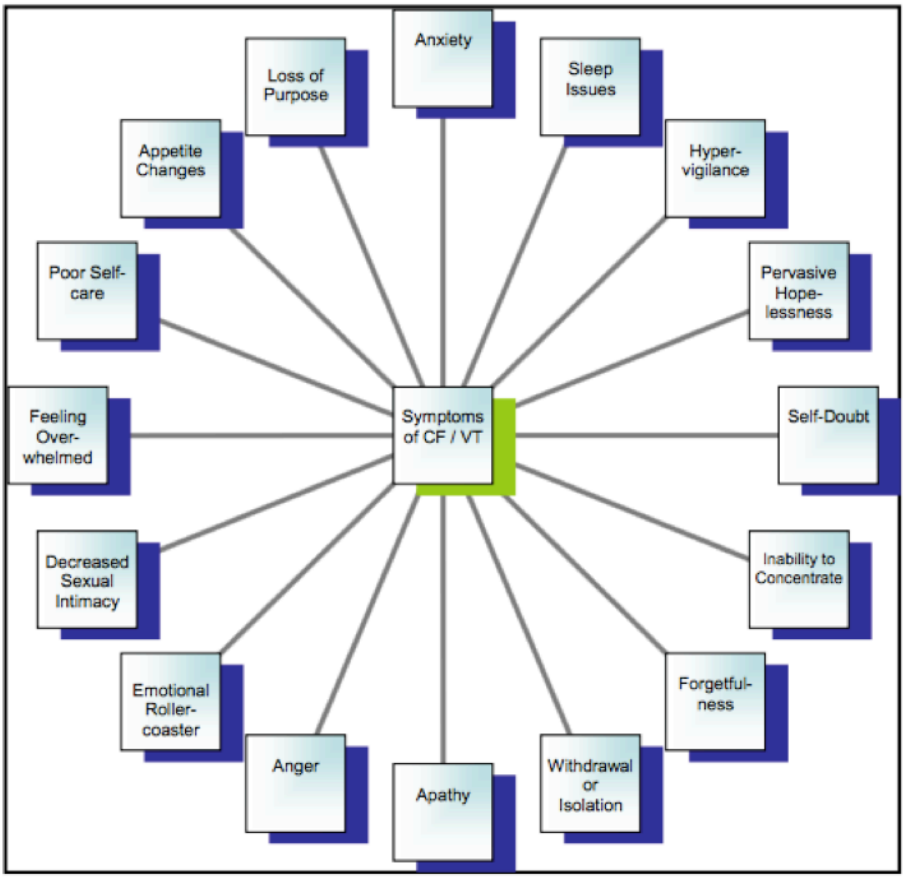
RESOURCES

Videos

Transforming Vicarious Trauma [Video file]. (n.d.).

Topic 2: Warning Signs of VT/STS

The following graphic identifies the breadth of possible symptoms of compassion fatigue and VT/STS (Mattison, 2012).



Topic 3: Self Assessment and Strategies

There are a variety of surveys, evaluation tools and self-assessment instruments that can help students to identify their strengths and needs. A list of instruments is provided. It is important to note that these are not meant to be diagnostic instruments.

- ProQOL (Professional Quality of Life Scale): The ProQOL is the most commonly used measure of the negative and positive results of helping others who experience suffering and trauma. The ProQOL has sub-scales for compassion satisfaction, burnout and compassion fatigue.
- Stress Test: Check list for recent stressful events automatically calculates your overall stress level.
- Self-care Assessment Worksheet: This assessment tool provides an overview of effective strategies to maintain self-care. After completing the full assessment you choose one item from each area that you will actively work to improve. Source: Transforming the Pain: A Workbook on Vicarious Traumatization. Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996).

Topic 4: The ABCs of Addressing VT

Pearlman encourages the ABC approach to managing the risk for VT, which includes attending to the following domains: Awareness, Balance, and Connection. It is recommended that trainees utilize the ABCs of Managing Secondary Trauma worksheet, and that they are encouraged to develop a plan to mitigate their own risk for VT.

Additionally, The University of Buffalo's School of Social Work provides a readily available "Self-Care Starter Kit" that assists individuals to develop self-care plans, provides assessments, and suggests various activities and exercises to encourage the emotional and physical health of caregivers. Also from University of Buffalo is this useful and easy-to-use resource, the Emergency Self Care Worksheet, which is closely aligned with the Sanctuary Model's Safety Plan.

RESOURCES

Self-Care Starter Kit

Emergency Self Care Worksheet

Additional Resources

Texts and Manuscripts

Courtois, C, (1993). Vicarious traumatization of the therapist. NCP Clinical Newsletter, Spring, '93.

Figley, C. (1995). Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. New York, NY: Brunner-Routledge.
Figley, C. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. Psychotherapy in Practice, 58(11), 1433-1441.

Joinson, C. (1992). Coping with compassion fatigue. Nursing 22(4), 116-122.

McCann, L. & Pearlman, (1990). Vicarious traumatization: A framework for understanding psychological effects of working with victims. Journal of Traumatic Stress, v.3.1.

Pearlman, L & Saakvitne, K. (1995). Trauma and the Therapist. WW Norton & Co.
Ruzek, J. (1993). Professionals coping with vicarious trauma. NCP Clinical Newsletter, Spring, '93.

Saakvitne, K. W., & Pearlman, L. A. (1996). Transforming the pain: A workbook on vicarious traumatization. London: W. W. Norton.

Handouts / Workbooks

ABCs of Managing Secondary Trauma worksheet

VT

Emergency Self Care Worksheet

Sanctuary Safety Plan

Mathieu, Francoise, Compassion Fatigue Workbook (excerpt)

Online Training Modules

Pearlman and McKay (2008). Understanding and addressing vicarious trauma.

The Best Start Resource Center: When Compassion Hurts

Videos

Headington has developed many resources and information related to vicarious trauma and secondary trauma.

Dr. Laurie Pearlman on Vicarious Trauma

Dr. Laurie Pearlman on Vicarious Transformation

Vic Compher. Portraits of Professional CAREgivers: Their Passion, Their Pain

Factsheets

American Counseling Association: VT

NCTSN Factsheet on VT

Web Resources

Bloom, Sandra. The Sanctuary Model

Mattison, T.M. (2012). Vicarious trauma: The silent stressor.

Meichenbaum, D. et al. (n.d.) Self-care for trauma psychotherapists and caregivers.

Pilot Course

Temple University School of Health Professions emerged as a possible partner for piloting the key concepts the Workgroup had identified. Temple's School of Social Work received a three-year grant award, from the Human Resources and Services Administration (HRSA), under the US Department of Health and Human Services, for an Advanced Clinical Education and Inter-professional Training (ACE IT) program. The project is co-directed by Drs. Cheryl Hyde, Marsha Zibalese-Crawford, Alan Pfeffer and Shirley Moy and is intended to provide to training to clinical social workers to improve their capacity to provide mental health services to at-risk youth. Temple approached the Health Federation of Philadelphia (HFP) about providing some foundational training on trauma informed practice to the students participating in the ACE-IT Program. HFP identified this as an opportunity to test out key concepts being developed by the Workforce Development workgroup. HFP staff, along with Jeanne Felter and Dianne Wagenhals, members of the PATF Workforce Development Workgroup, and Cynthia Shirley, MSW, LSW Senior Trainer at HFP, met several times with Temple faculty and staff to plan the foundational training workshop.

An agenda and accompanying set of slides were developed for this pilot (see Appendix B), which was conducted as a 3 hour workshop on September 11, 2015 at Temple University. Participants included the ACE IT student cohort, Temple faculty, ACE IT field supervisors and other students from Temple's Health Professions programs. The training was broadcast via WebEx for remote students in Harrisburg, PA and the surrounding area. Approximately 150 participants attended and were administered a pre- and post-evaluation to measure participant self-assessed knowledge.

Pilot Course Evaluation

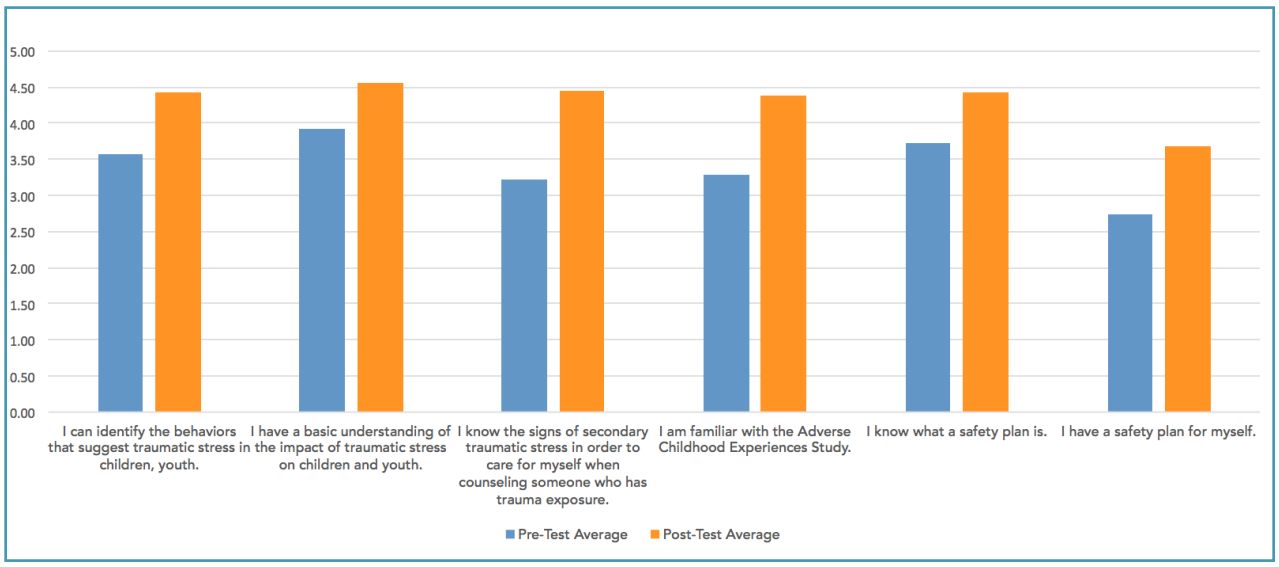
The pre- and post-test self-administered assessment results can be seen in Table 1 below. Many participants, it appears, came with some relevant base knowledge and the post-test suggests that the key concepts were useful in increasing participants' knowledge of trauma, the impact of trauma, the ACE Study, and the need for self-care made likely by the exposure to secondary trauma.

Temple University Evaluation Data

Table 1. Pre- and Post-test averages measuring level of agreement with each statement (1=Strongly Disagree; 5=Strongly Agree)

	Pre-Test Average	Post-Test Average	Mean Change
I can identify the behaviors that suggest traumatic stress in children, youth	3.56	4.42	24.16%
I have a basic understanding of the imapct of traumatic stress on children and youth	3.93	4.55	15.78%
I know the signs of secondary traumatic stress in order to care for myself when counseling someone who has trauma exposure	3.22	4.44	37.89%
I am familiar with the Adverse Childhood Experiences Study	3.28	4.39	33.84%
I know what a safety plan is	3.73	4.43	18.77%
I have a safety plan for myself	2.73	3.69	35.16%

Change in Understanding of Trauma Informed Principles as a result of Temple Workshop



Conclusion

This project was a great beginning for the work of the Philadelphia ACE Task Force Workforce Development Workgroup. It is hoped that this Toolkit will serve as useful information and a set of key concepts that can be used by faculty members and others seeking to integrate this important content into existing courses and to create new courses that cover this subject matter.

Acknowledgements

We would like to recognize the Health Federation of Philadelphia and their key staff, Carolyn Smith-Brown and Leslie Lieberman, and who ably shepherded this project. We also wish to acknowledge Caitlin O'Brien and Shoshana Akins who developed the Environmental Scans and data for the Evaluation as part of the master's projects for the Thomas Scattergood Behavioral Health Foundation. Very special thanks to Jeanne Felter for her extensive research on and writing of the Key Concepts section of this report and the inclusion of many useful resources. Many thanks and appreciation to the Temple University faculty and staff of the School of Social Work and ACE IT program that made this pilot of key concepts possible - Shirley Moy, Ryan Villagran and Alan Pfeffer, Marsha Zibalese-Crawford and Cheryl Hyde. Deep gratitude to Cynthia Shirley, MSW, LSW, for her excellent presentation to the Temple School of Social Work for the pilot and to the students, field supervisors and faculty that participated.

Special thanks also to the National Center for Social Work Trauma Education and Workforce Development (NCSWTE) for consulting with us and presenting at the Philadelphia ACE Task Force.

Philadelphia ACE Task Force – Workforce Development Group Project Members

Shoshana Akins, MPH	The Thomas Scattergood Foundation for Behavioral Health
Leann Ayers, MGA	Annie E. Casey Foundation Fellow, Class 4
Steve Berkowitz, MD	University of Pennsylvania
Joel Fein, MD	Children's Hospital of Philadelphia
Jeanne Felter, PhD	Philadelphia University
Alyson Ferguson, MPH	The Thomas Scattergood Foundation for Behavioral Health
Risa Mandell, LCSW	Einstein Medical Center
Caitlin O'Brien, MPH	The Thomas Scattergood Foundation for Behavioral Health
Suzanne O'Connor	United Way of Southeastern Pennsylvania and Southern New Jersey
Carolyn Smith-Brown	The Health Federation of Philadelphia
Diane Wagenhals, MEd	Lakeside & Institute for Family Professionals

Appendix A Sample Slide Deck for ACEs, Trauma and Resilience Course Content

the ACE Study

http://www.acestudy.org/

Kaiser Permanente Medical Group

Centers for Disease Control and Prevention (CDC)

ADVERSE CHILDHOOD EXPERIENCES (ACE)

- The largest scientific research project of its kind to date
- A decade long ongoing collaboration led by:
  - Vincent J. Felitti, MD
  - Robert F. Anda, MD, MS
- Analyzing the relationship between multiple categories of childhood trauma and health and behavioral outcomes later in life.

1

What do we mean by ACEs?

ACE SCORE CALCULATOR (Scale 0-10)

- Emotional Abuse
- Physical Abuse
- Sexual Abuse
- Emotional/Physical Neglect
- Domestic Violence – Battered Mother
- Single Parent Homes – Due to Separation/ Divorce/Death
- Substance Abuse - One or Both Parents
- Incarcerated Parent(s)
- Parent(s) Suffering From Mental Illness
- Parent(s) Suffering From Chronic Illness

Chapman, Whitfield, Felitti, Dube, Edwards, & Anda , 2004

From Dr. Patty Gerrity and Dr. Roberta Waite, *The Healing Project*

2

Adverse Childhood Experiences

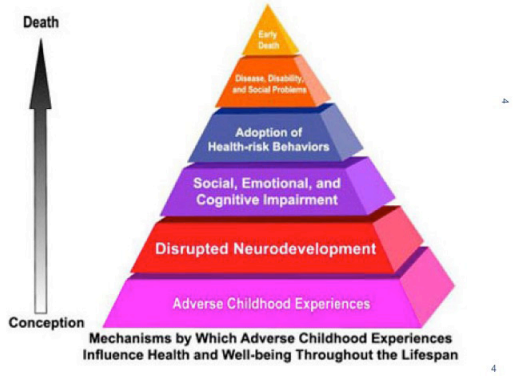
A
- 17,000 adults
- 10 types of adverse experiences

C
- Only 1/3 had *NO* ACES
- 16% had *4 or more* ACES

E
- More ACES were STRONGLY correlated with significantly poor health outcomes and health risk behaviors

3

ACE STUDY, 1999 – Anda & Felitti



Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

4

THE PHILADELPHIA ACE PROJECT

- Conducted as a follow-up module in conjunction with the Household Health Survey (HHS)—phone interviews
- 1,784 Philadelphians interviewed
- Created 5 new Expanded ACEs, that are "Community-Level" indicators:
  - Experiencing discrimination or racism
  - Witnessing violence
  - Living in an unsafe neighborhood
  - Living in foster care
  - Experiencing bullying

http://www.philadelphiaaces.org/philadelphia-ace-survey

5

- **Trauma is not an event itself; it is a RESPONSE to a stressful experience in which a person's ability to cope is dramatically undermined.**
- Massachusetts Advocates for Children, 2005

A wide range of experiences can result in childhood trauma, and a child's response to events vary depending on:

Characteristics of the child (*e.g.*, age, stage of development, personality, intelligence and prior history of trauma)
Environment (*e.g.*, school and family supports),
Experience (*e.g.*, relationship to perpetrator).

6

Prevalence of Trauma

- More than 5,000,000 US children experience extreme traumatic events such as:
  - Natural disasters
  - Car or other motor vehicle accidents
  - Life threatening illness and related painful medical procedures
  - Kidnapping
  - Sudden death of a parent
  - Physical Abuse, Sexual Assault
- More than 2,000,000 per year
  - Witness domestic or community violence
- By age 18 there is a 1 in 4 chance that a child will have been touched directly by interpersonal or community violence.

Perry, 2001, 1999

7

- Trauma creates a stress response
- This stress can be episodic or long lasting
- Where people's response falls on the continuum between "motivational" stress and toxic stress will determine the impact of the experience.

- Good Stress

- Toxic Stress

8

As many as two out of every three children have been exposed to at least one traumatic event before the age of 16.

http://www.samhsa.gov/children/dropin_trauma_elementary.asp

What is trauma?

- Sudden
- Unexpected
- Perceived as dangerous
- Threat of physical harm or actual physical harm
- Intense fear, helplessness
- Overwhelms our immediate ability to cope

9

Three primary categories of response

- *Fight*: Physical Arousal
  - Aggression
  - Trouble concentrating
  - Hyperactivity
- *Flight*: Withdrawal and Escape
  - Social isolation
  - Avoidance of others
  - Running away
- *Freeze*: Stilling and Constricting
  - Constricted emotional expression
  - Stilling behavior
  - Over compliance and denial of needs

10

Psychological Trauma

Traumatic events "overwhelm the ordinary systems of care that give people a sense of control, connection and meaning."

Herman, 1997, p. 33

11

Exposure to Trauma

Trauma can be:

- A single event
- A connected series of events
- Chronic lasting stress

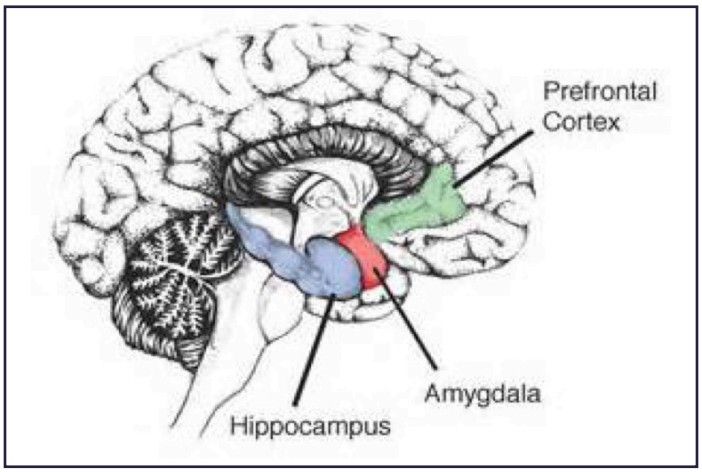
Trauma is under-reported and under-diagnosed.

(NTAC, 2004)

Used with permission from Trauma Informed Florida Project http://www.djj.state.fl.us/trauma-informed-care/index.html

12

13



14

HIPPOCAMPUS

Our Memory Keeper

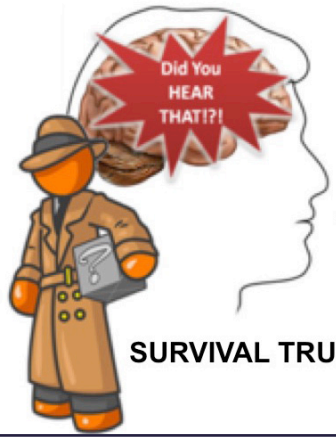
- Is impacted by intense emotions and fear
- When hyper-aroused or hyper-vigilant, we don't remember well
- Helps to us to assess whether an event is "truly dangerous".

15

AMYGDALA = ALARM SYSTEM

- Plays role in processing of emotions
- Central to survival, arousal, autonomic responses
- Associated with
  - FEAR
  - HORMONAL SECRETIONS
  - IMPLICIT (EMOTIONAL) MEMORY

16



Stored early implicit memories can cause

AMYGDALA HIGHJACK

Without the person's conscious knowledge

SURVIVAL TRUMPS EVERYTHING!

17

PRE-FRONTAL CORTEX

Planning
Organizing
Regulating Attention
Decision Making
Moderating behavior
Personality expression
Motivation
Mood

18

Behavior is a child's language.

Remember developmental versus chronological age

19

Impact on Relationships

- Relationships are developed through the emotional bond between the child & primary caregiver. It is through this relationship we learn to:
  - Regulate emotions/"self soothe"
  - Develop trust in others
  - Freely explore our environment
  - Understand ourselves & others
  - Understand that we can impact the world around us

20

Impact on Learning

- Organizing narrative material
- Cause & effect
- Taking another's perspective
- Attentiveness
- Regulating emotions
- Executive functioning
- Engaging in curriculum

21

Impact on Behavior

- Reactivity & impulsivity
- Aggression
- Defiance
- Withdrawal
- Perfectionism

22

Triggers

Seeing, feeling, hearing, smelling something that reminds us of past trauma

Activates the alarm system…

The response is as if there is current danger.

Thinking brain automatically shuts off in the face of triggers.

Past and present danger become confused.

Used with permission from Trauma Informed Florida Project
http://www.dij.state.fl.us/trauma-informed-care/index.html

23

The Problems with Triggers Are . . .

- Rarely clear
- Often unnoticed, even by the individual
- Can be invisible (sensory oriented)
- Can seem trivial/minor
- Are often uncontrolled factors
- Don't always make sense
- Revert us to less functional versions of ourselves

24

SO WHY BE TRAUMA INFORMED?

- Trauma is pervasive and its impact is far reaching and long lasting
- Trauma affects how people approach services designed to help them
- Services designed to help people can be and often have been inadvertently re-traumatizing
- Recovery and healing are possible
- Protective factors facilitate healing and resilience
- ***Healing occurs within the context of RELATIONSHIPS.***

(Fallot and Harris, 2002)

25

WHAT DOES IT MEAN TO PROVIDE TRAUMA INFORMED SERVICES?

- Trauma informed care delivers services, (mental health, legal, child welfare, education, public health, addiction, housing supports, vocational or employment counseling services, etc.,) in a manner that ***acknowledges the role that trauma***, (violence and victimization) plays in the lives of many people seeking these services . . .

(adapted from Harris and Fallot, 2001)

26

WHAT ARE TRAUMA-SPECIFIC SERVICES?

- Designed to treat the actual "symptoms" of traumatic experiences (e.g. PTSD, Complex Trauma, Trauma related depression)
- Provided by trained mental health clinicians
- Often combine psycho-education, cognitive behavioral therapy and are phase-oriented
- Include concepts of trauma-informed services

27

Trauma-Informed Care: *Howard Bath*

28

Safety

- Healing begins by creating an atmosphere of safety (emotional, relational, physical, psychological)
- Consider your setting
- Consider how services are provided (consistency, transparency, affect and behavior of provider(s)
- Consider the experience of the child and family
- Provide opportunities for choice and control

29

Connections

- The connection between traumatized individuals and their provides is essential to the healing process
- "..on average, the qualities of the therapeutic relationship itself account for twice as much positive change as the specific therapeutic techniques used. (Asay and Lambertson, 2009)
- The brains of traumatized children have learned to associate adults with negative emotions

30

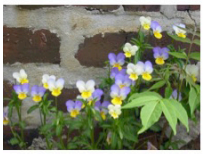
EMOTIONAL MANAGEMENT

- The ability to manage emotions and impulses are essential skills for healthy development.
- Exposure to trauma can undermine the capacity to effective manage emotions and impulses.
- The primary source for skills to modulate emotion should be parents/caregivers.
- Where this did not occur in the family or if traumatic experiences have disrupted or undermined this capacity, there are interventions available to teach emotional regulation
- Children may also need adults to "co-regulate" with them.

31

Building Resiliency

- At least one supportive adult
- Positive outlook
- Problem solving skills
- Hobby, interest, curiosity
- Goals, hopes, dreams
- Being needed by others
- Positive memories, images to hold onto



32

- "Secondary Traumatic Stress (STS) is the emotional duress that results when an individual hears about the first-hand trauma experiences of another….Accordingly, individuals affected by secondary stress may find themselves re-experiencing personal trauma or notice an increase in arousal or avoidance reactions related to the indirect trauma exposure."

National Child Traumatic Stress Network (NCTSN)

33

Know the warning SIGNS

- Increased irritability or impatience with clients
- Difficulty planning and implementing work responsibilities
- Decreased concentration
- Denying that traumatic events impact clients or feeling NUMB or DETACHED ("I just don't care.")
- Intense feelings or intrusive thoughts about clients
- Dreams about clients/sleep problems
- Changes in eating—more or less
- Increased use of stimulants, alcohol, cigarettes, spending or food to make it through the day/ week

34

[Download Presentation Slide Deck Here]

Appendix B Environmental Scan

View the reports on the National and Philadelphia Region Environmental Scans

Citations

Bath, H. (2008). The three pillars of trauma informed care. Reclaiming Children and Youth, 17-21. Link: https://s3-us-west-2.amazonaws.com/cxl/backup/prod/cxl/gklugiewicz/media/507188fa-30b7-8fd4-aa5f-aa5f-ca6bb629a442.pdf

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