Trauma Informed Care Toolkit

Information for Professionals

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What is Trauma and How Does It Affect Adolescents?

Trauma and toxic stress refer to intense experiences that threaten the safety and security of individuals. Traumatic experiences can have short and long term affects. This section provides an overview of trauma and its impact on youth. It also includes a power point presentation that can be used for staff in a variety of settings as well as parents/caregivers.

Trauma Definitions

The following terms are frequently used when talking about trauma/toxic stress.

Stress: any experience that disrupts our sense of well-being.
Trauma: an intense event that threatens safety or security of an individual.
Toxic Stress: recurring negative experiences that threaten safety or security.
Acute Trauma: a single, time-limited traumatic event.
Chronic Trauma: multiple traumatic exposures/events over an extended period of time.
Traumatic Stress: long term reaction to trauma; refers to the combination of the event, the individual's experience/perception and the effects.
Complex Trauma: experience of multiple traumatic events & impact of that experience.

Trauma and Stressor-Related Disorders

The DSM-5 describes several trauma related disorders including:
Posttraumatic Stress Disorder- the clinical presentation of PTSD varies and may include one or more of the following constellation of symptoms which persist for more than 1 month after exposure to trauma:

- fear-based re-experiencing, emotional and behavioral symptoms
- anhedonic or dysphoric mood states or negative cognitions
- arousal and reactive-externalizing symptoms
- dissociative symptoms

Acute Stress Disorder- symptoms may occur in the categories of intrusion, negative mood, dissociation, avoidance and arousal which begin after exposure to trauma and persist for 3 days to 1 month.

Adjustment Disorders- emotional or behavioral symptoms which develop in response to an identifiable stressor and occur within 3 months of the stressor; symptoms may include depressed mood, anxiety, mixed anxiety and depression, conduct disturbance, or mixed disturbance of emotions and conduct.

Reactive Attachment Disorder- characterized by a pattern of markedly disturbed and developmentally inappropriate attachment behaviors evident in infancy or early childhood and in which the child rarely or minimally turns to an attachment figure for comfort, support, protection and nurturance.

Disinhibited Social Engagement Disorder- a pattern of behavior that involves culturally inappropriate, overly familiar behavior with relative strangers.

Adapted from Diagnostic and Statistical Manual of Mental Disorders 5th Edition.

Impact of Trauma/Toxic Stress

All stress generates physiological and behavioral responses. Physiologically the body responds with elevated blood pressure and heart rate and increased levels of the hormones cortisol and adrenaline. These responses increase the brain's alertness and the body's ability to respond. Behavioral responses follow from these physiological changes and include the well-known responses of fight, flight and/or freeze. These responses to stress are valuable and help us adapt to and cope with the challenges that come our way. Often they literally help us survive.

However, responses to stress are meant to be temporary and short term. When the physiological and behavioral responses to stress persist for an extended period of time, there can be negative consequences for our health and well-being. In recent years, two areas of research have enhanced our understanding of the impact of trauma and toxic stress and the mechanisms that facilitate the negative consequences.

The ACEs Study

The Adverse Childhood Experiences Study (ACEs) was conducted in 1997 by Dr. Vincent Felitti at Kaiser Permanente and Dr. Richard Anda at the CDC. They reviewed the health history and current health of 17,000 adult patients (mostly white, middle aged and middle class). They asked each participant to identify how many adverse childhood experiences they had experienced before the age of 18. The participants identified the events from a list of 10 experiences that included abuse (physical, emotional & sexual), neglect (physical & emotional), and family dysfunction (mental illness, substance abuse, domestic violence, caregiver incarceration and separation from a caregiver). Each participant was assigned an ACE score equal to the total number of adverse experiences.
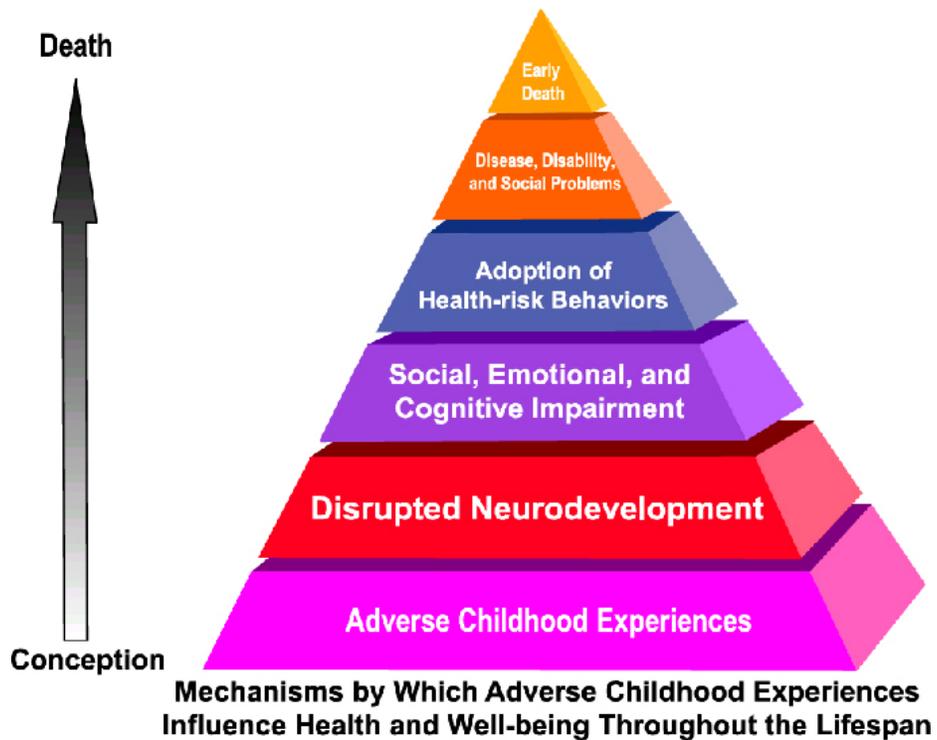
The findings revealed that ACES are common:
- 64% of adults had experienced at least one ACE
- 12% had experienced 4 or more ACEs
- In general women experienced more ACEs than men

When the number of ACE scores was compared to a variety of health risk behaviors, behavioral health problems and physical health problems, the findings were dramatic. For example when the ACE score was 4 or higher the individual was:
- Twice as likely to smoke cigarettes
- 7 times more likely to be an alcoholic
- 10 times more likely to have injected street drugs
- 12 times more likely to have attempted suicide
- 3 times more likely to experience chronic depression
- The risk for hepatitis and sexually transmitted diseases was 240% greater
- The risk for COPD was 390% greater

Dr. Felitti and Dr. Anda developed a model to illustrate the mechanism by which childhood experiences influence health and well-being throughout the lifespan.

Death

Conception

Early Death

Disease, Disability, and Social Problems

Adoption of Health-risk Behaviors

Social, Emotional, and Cognitive Impairment

Disrupted Neurodevelopment

Adverse Childhood Experiences

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

For more information about the ACE study click here:
http://www.cdc.gov/violenceprevention/acestudy/

Neuroscience and Epigenetics

There has also been a great deal of recent research related to the factors that influence neurodevelopment. This so called "brain science" highlights the powerful influence played by the physical environment and social experiences on the developing brain as well as our cognitive, social and emotional abilities.

The concept of epigenetics provides further evidence that the environment and our experiences influence human development by chemically altering which genes are "turned on" or "turned off". These changes in the expression of our genetic blueprint can be passed from one generation.
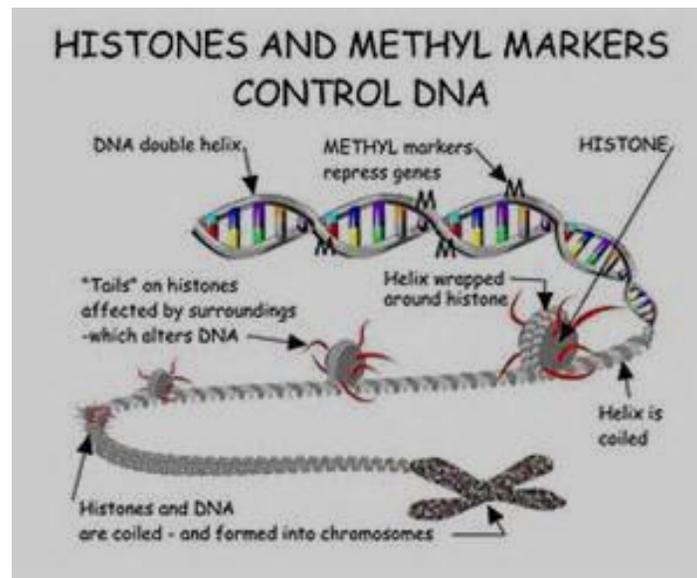

Both the neuroscience and epigenetic research acknowledge two critical developmental periods – early childhood and adolescence. During both of these periods specific areas of the brain are undergoing significant growth and maturation. Thus these two periods represent windows of vulnerability and opportunity for human development and both positive and negative experiences are particularly impactful at these times.

The impact of trauma during childhood, especially early childhood and adolescence, can be profound. Early, chronic and toxic stress can "hard wire" the brain to respond as if trauma is ongoing in the present leading to traumatic stress disorders such as PTSD. "Sensory input, memory formation and stress response mechanisms are affected in patients with post-traumatic stress disorder (PTSD). The regions of the brain involved in memory processing that are implicated in PTSD include the hippocampus, amygdala and frontal cortex. While the heightened stress response is likely to involve the thalamus, hypothalamus and locus coeruleus." (CNS Forum Lundbeck Institute)
https://www.cnsforum.com/educationalresources/imagebank/brain_struc_anxiety/neuro_biol_ptsd
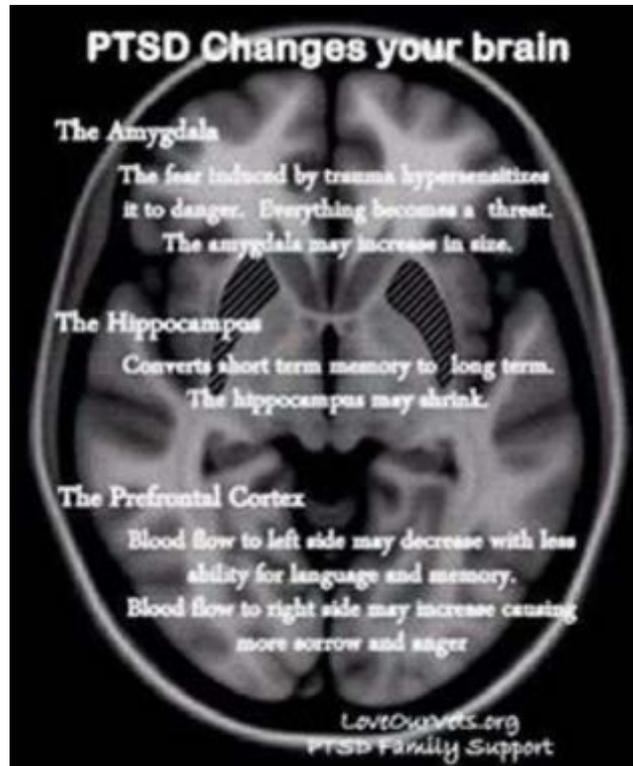
Source: Coping.us Neuroscience of Mental Health Disorders
http://coping.us/neuroscience/neurosciencemhdisorders.html

Learn more about neuroscience and epigenetics see **Resources.**

Adolescent Brain Development

Adolescence is a time of enormous opportunity and vulnerability. The rapid physical, emotional and neurological changes that take place in adolescence are similar in scope to early childhood.

Our brain and neurological system begin developing prenatally and that development follows a fairly prescribed progression from pre-birth into young adulthood. The brain develops in terms of size (numbers of neurons and neuronal connections) as well as function (simple to complex abilities). The pre-frontal cortex is the final portion of the brain to develop and the period of most intense growth and maturation takes place during adolescence. This area of the brain is responsible for "executive function" which includes focused attention, problem solving, anticipating consequences and emotional regulation. During early adolescence the pre-frontal cortex begins a period of rapid growth. There is an explosion of new neurons and new connections between neurons. This increased capacity is influenced by the environment. If the environment is stimulating and safe, the cortex develops executive functions with relative ease. If however, the environment is threatening and unsafe or the brain is in a state of constant alarm due to previous chronic stress, the maturation of the pre-frontal cortex will be derailed. In middle adolescence the pre-frontal cortex undergoes a process of "pruning". This process involves removing neural connections that are infrequently used and strengthening those connections that are more frequently used. For example, if neurons associated with weighing pros and cons of situations are used

regularly in response to the environment, they will be strengthened. While if neurons and neural connections associated with a high level of reactivity are more frequently used they will be strengthened. The pruning process is directly connected to the individual's experiences and environment.
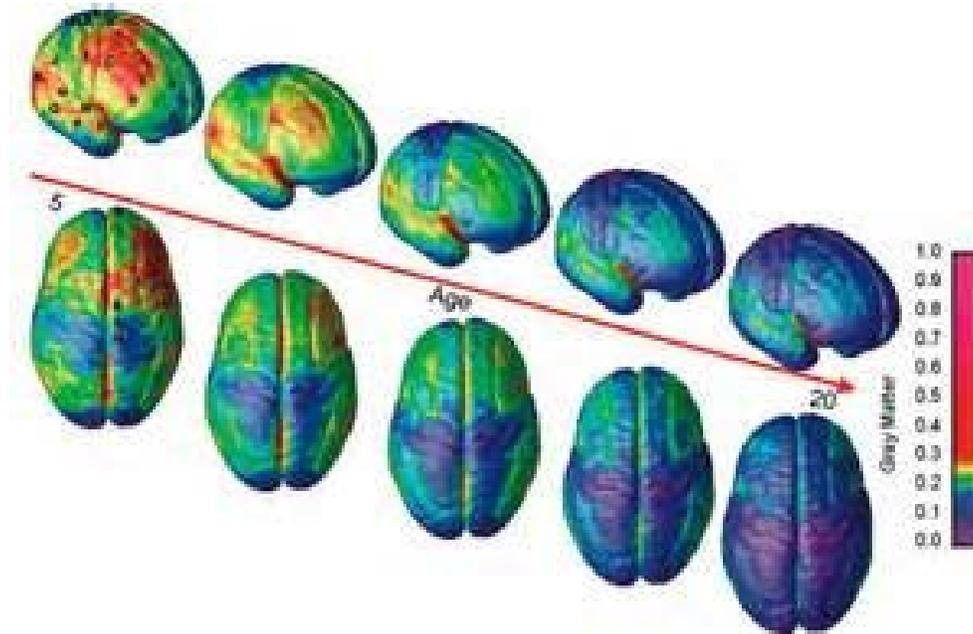
Another active area of the brain during adolescence is the amygdala. The amygdala is in the central part of the brain and develops early in life. It is the emotional center of the brain. The amygdala becomes more active during adolescence due to increased hormonal levels in the body. If hormones associated with stress (cortisol and epinephrine) are high the amygdala will respond by readying the individual for fight, flight or freeze responses. The amygdala also processes hormones associated with pleasure, fear and safety. It communicates with other parts of the brain to elicit responses appropriate to the emotional/hormonal inputs. If there are more fearful messages from the amygdala, those responses will become more "hard wired" in the pruning phase of pre-frontal cortex development.

A final and related process that occurs during adolescence is myelination. This refers to a process whereby a fatty sheath is deposited around the neurons and neural connections. This layer of fat serves as an insulator and increases the speed and efficiency with which neurons communicate with each other. Myelination increases the "hard wiring" effect of pruning by further enhancing those neural connections that are frequently used.

Adolescence is a critical period for brain development. The specific functions and capacities that are developed and "hard wired" in adolescence become the default way that an individual responds to new situations and challenges. Those default responses can be altered later in life but it is more difficult. Adolescents have the opportunity to develop and hard wire a host of adaptive cognitive, emotional and social skills that will lead to healthy and successful adult lives. They are also vulnerable to developing

fear-based and maladaptive patterns that lead to impaired physical, emotional and social functioning and may lead to early death.

For more information about adolescent brain development, see **Resources**.

Trauma Informed Care and Organizations

Trauma informed care or a trauma informed approach refers to the organizational context in which care or services are provided. Trauma informed care goes beyond a particular assessment or treatment approach and takes into account organizational policies and practices that can positively or negatively impact children, families and staff. Trauma informed care recognizes that organizational practices may in fact be traumatizing and that assessing organizational practices critically is a component of providing comprehensive services for children and families.

SAMHSA issued guidelines for trauma informed care in 2014 that outlined four assumptions, six key principles and ten implementation domains for trauma informed care.

The **Four Key Assumptions** include:
Realization about trauma and its impact on individuals, families and communities
Recognition of the symptoms of trauma and traumatic stress
Responses that are trauma informed at all levels of the organization
Resistance to re-traumatization at all levels including at the staff level

The **Six Key Principles** include**:**
1. Safety
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice and Choice
6. Cultural, Historical and Gender Issues

The **Ten Implementation Domains** Include:
1. Governance and Leadership
2. Policy
3. Physical Environment
4. Engagement and Involvement
5. Cross Sector Collaboration
6. Screening, Assessment and Treatment Services
7. Training and Workforce Development
8. Progress Monitoring and Quality Assurance
9. Financing
10. Evaluation

A complete copy of the guidelines is available at: http://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf

Another valuable resource for developing trauma informed care in organizations is a web-based tool developed by JBS International and Georgetown University National Technical Assistance Center for Children's Mental Health. The website entitled, "Trauma Informed Care: Perspectives and Resources",

includes videos, issue briefs and resources to assist in the implementation of trauma informed care in a variety of settings. It identifies specific examples of trauma informed practices across a variety of child-serving organizations and discusses trauma as a public health problem.

The website is available at http://trauma.jbsinternational.com/Traumatool/index.html.

Trauma Screening and Assessment

Screening for trauma recognizes the pervasiveness of trauma/toxic stress in the lives of youth. It is designed to shift the focus from "what is wrong?" to "what has happened?"

Screening for trauma and toxic stress may identify exposure to traumatic experiences/ events and/or the presence of one or more symptoms of traumatic stress. A trauma screening tool may be universally administered or may be used as a secondary tool with individuals who have identified behavioral risks/issues using a more general risk assessment tool.

Screening tools are generally short and easily completed and scored. They offer an opportunity to discuss a teen's experiences and decide together what, if any, further intervention is needed or desired. They are not usually used for diagnostic purposes.

Some organizations combine trauma screening with resilience screening. Resilience screening tools are used to identify areas of strength and support in the individual's life. They can be a starting point for helping a teen to develop healing and coping strategies.

Some of the more commonly used trauma screening tools include:
- ACEs Questionnaire
- Primary Care PTSD Screener
- UCLS PTSD Index
- WMU Child Trauma Assessment Center Screening Checklist
- Multidimensional Grief Reaction Scale

Trauma assessment involves a more in-depth assessment of an individual's symptoms and is used to assist with treatment planning. Trauma assessments include information about trauma exposure, symptoms and functional impairments associated with trauma. Trauma assessment tools focus on DSM-5 criteria and yield a diagnostic determination.

Some commonly used trauma assessment tools include:
- Child PTSD Symptom Scale (CPSS)
- Trauma System Checklist for Children (TSCC)
- Child and Adolescent's Needs and Strengths-Trauma versions (CANS)

The National Child Traumatic Stress Network maintains a database of screening and assessment tools related to trauma and toxic stress.

http://www.nctsn.org/resources/online-research/measures-review

The VA National Center for PTSD also maintains a database of child measures of trauma and PTSD.

http://www.ptsd.va.gov/professional/assessment/child/index.asp

Trauma Specific Treatments

There are a variety of individual and group-based treatment models that have been developed to address trauma and traumatic stress disorders. Selecting a particular treatment model depends on a number of factors including the population that is being served, the skills and preferences of the provider and organizational factors including space, time constraints, etc. Many trauma-specific treatments are evidenced-based indicating that research has been conducted to demonstrate effectiveness and efficacy of the model. Training is often provided by the model developer or related organization. Training may be available on-line or in person and costs vary.

Information about trauma-specific treatment models is available through the following:

SAMHSA's National Registry of Evidenced-Based Practices and Programs – provides a description of each intervention including research results, costs and contact information.
http://www.nrepp.samhsa.gov/ViewAll.aspx

Trauma Informed Care: Perspectives and Resources Module 4 Evidenced-Based Treatments Addressing Trauma – provides written and video descriptions of some treatment models.
http://trauma.jbsinternational.com/Traumatool/Module4.html

Many treatment modules also have web-based materials available to help clinicians determine the appropriateness of a specific model for their practice and population.

Trauma Prevention/Early Intervention

Developing a culture that reduces the incidence of trauma and enhances protective factors and resilience can impact all students, including severely and mildly affected youth. Identifying traumatic stress and providing trauma-specific treatment are important aspects of trauma informed care. For school-based health clinics it is also important to address the needs of those who may not be exhibiting symptoms of traumatic stress disorders and to prevent trauma and its effects in the future.

Prevention and early intervention strategies may be very broad in nature, for example strategies that promote social emotional health and conflict resolution. Or they may be targeted, for example interventions aimed at preventing and responding to bullying, suicide prevention activities or promotion of healthy relationships. All of these interventions support the concepts of respectful communication, compassion, and safety. They also encourage youth to develop skills that enhance their coping abilities and resilience.

For young people the single most important factor in reducing or preventing the negative impact of trauma and toxic stress is the presence of supportive relationships in their lives. These relationships provide a valuable buffer to the impact of trauma and allow the youth to develop and recognize their strengths and resilience.

Supportive relationships make it possible for individuals to avoid or heal from post-traumatic stress disorder and instead develop post-traumatic growth. Post traumatic growth occurs when the individual finds meaning in the trauma and learns lessons for the future. It involves positive changes in self-perception (e.g. victim to survivor), improved and deeper relationships, increased compassion for others, and increased ability to express emotions. Post traumatic growth encourages an individual to heal from past trauma and avoid or successfully face future trauma.

Additional information about developing resilience and positive coping strategies is available in the **Resources** section of this toolkit.

Secondary Traumatic Stress

Secondary traumatic stress or compassion fatigue is the distress that can arise from hearing about the trauma of others. Professionals who work with traumatized individuals are at high risk for developing secondary traumatic stress. It is difficult to listen deeply and respond empathically to the pain of others without being affected. Secondary traumatic stress is personally harmful and also impacts our ability to function effectively in our role as helpers. In addition it can contribute to high turnover rates in the helping professions. It is important to learn about secondary traumatic stress and its symptoms and take action to prevent and intervene for those who are at risk or have developed secondary traumatic stress.

There are several terms that are often used interchangeably to describe secondary traumatic stress. However, the terms have somewhat different meanings.

Secondary Traumatic Stress refers to the presence of PTSD symptoms, including fearfulness, difficulty sleeping, intrusive images of the trauma or avoidance, caused by at least one indirect exposure to traumatic events/material.
Compassion Fatigue is a less stigmatizing term that describes secondary traumatic stress and is often used interchangeably. It is the negative aspect of helping those who experience traumatic stress and suffering.
Vicarious Trauma refers to changes in the internal experience of the therapist resulting from empathic engagement with a traumatized client. It focuses more on the cognitive changes that occur following cumulative exposure to another person's traumatic experiences.
Burnout is a more general term that refers to occupational stress and is characterized by emotional exhaustion, depersonalization and a reduced feeling of personal motivation and accomplishment. It is usually work-related but does not necessarily describe the effects of indirect trauma exposure.
Compassion Satisfaction this is a related concept that refers to the positive feeling you derive from being able to work with individuals who are suffering.

Addressing Secondary Traumatic Stress

Organizations and individuals have a responsibility to address secondary traumatic stress in order to foster a healthy and effective workforce. Taking steps to address secondary traumatic stress is an integral component of a trauma informed approach.

The following table identifies some prevention and intervention strategies for individuals and organizations.

Prevention/Intervention Strategies	
Organizations	**Individuals**
Train staff about secondary traumatic stress	Learn about secondary traumatic stress & self-care
Enhance physical safety of staff	Be aware of & follow safety procedures at work
Provide regular, non-judgmental, reflective supervision	Utilize supervision to address secondary traumatic stress
Balance caseloads relative to trauma	Maintain healthy work-life balance
Encourage time-off & flexible scheduling	Develop & implement plans for self-care and wellness
Offer workplace self-help and wellness activities	Practice self-care including good nutrition, healthy sleep and exercise
Provide ongoing assessment of staff risk & resiliency	Be aware of your own stress level and be proactive in addressing your needs, utilize risk assessment tools
Provide linkage to treatment providers thru EAP and/or external providers	Utilize counseling services as needed