TRAUMA & RESILIENCE

AN ADOLESCENT PROVIDER TOOLKIT

ADOLESCENT HEALTH WORKING GROUP

AHWG

THE ADOLESCENT HEALTH WORKING GROUP (AHWG)

History: The AHWG was formed in 1996 by a group of adolescent health providers and advocates concerned about the lack of age-appropriate health services for young people in the city of San Francisco.

Vision: All youth have unimpeded access to high quality, culturally competent, youth friendly health services.

Mission: Support and strengthen the network of providers working to improve adolescent health.

Core Functions:

1) Develop tools and trainings that increase providers' capacity to effectively serve youth/young adults.

2) Advocate for policies that increase access to care and utilization of youth/young adult services.

3) Convene stakeholders and coordinate linkages across systems to improve information sharing, networking, and referrals for youth/young adult services.

Fiscal Sponsor: The AHWG is a project of the Tides Center.

Additional Info: www.ahwg.net

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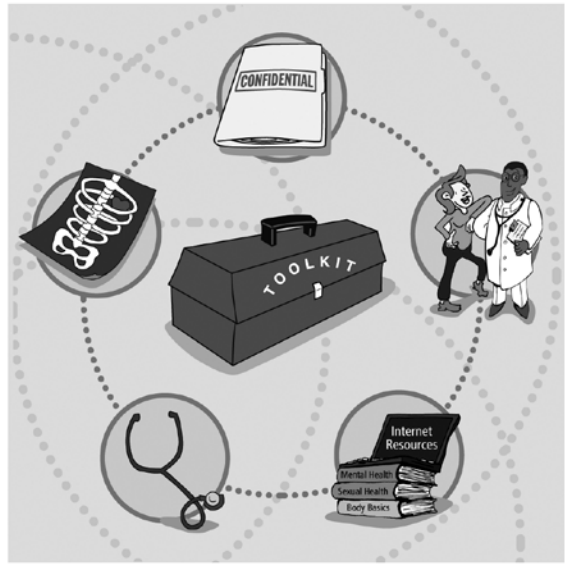

Illustrations by Jordan Zaini, 17

THE AHWG ADOLESCENT PROVIDER TOOLKIT SERIES

The toolkit consists of five modules:

1. Adolescent Health 101 (2003)
2. Body Basics (2004)
3. Understanding Minor Consent and Confidentiality in CA (2003, 2010)
4. Behavioral Health (2007)
5. Sexual Health (2010)
6. Trauma & Resilience (2013)

Designed for busy providers, each module addresses a complexity of issues through accessible, user-friendly resources including screening and assessment tools, evidence based best practices and promising approaches, and health education handouts for youth/young adults and parents/caregivers. The toolkit series, developed locally, has been distributed and utilized by providers nation wide. Accompanying training has also been developed and delivered locally and regionally to health plans, community clinics, and educators.

For more information on AHWG resources, training, and events, please visit:

www.ahwg.net.

TRAUMA & RESILIENCE

Trauma & Resilience, the sixth module of the AHWG Adolescent Provider Toolkit Series, was created in response to a continued demand among providers for resources focused on the intersections of health and violence.

The Trauma & Resilience toolkit module is designed to:

1) Encourage paradigm shifts from:
   - Trauma to resilience
   - Deficits to assets
   - Oppression to empowerment
   - Individuals to systems

2) Increase communication and collaboration among different service sectors and systems of care including: health, education, juvenile justice, workforce development, human services, housing, and youth/young adult development programs.

The Trauma & Resilience toolkit module is designed for:

- All levels of youth/young adult service providers, from front line staff, to clinicians, to administrators.

Youth Handouts

- Handouts specifically designed for youth/young adults are starred and underlined in the Table of Contents.
- Youth handouts may also be useful with parents/caregivers and community members, as deemed appropriate by providers, and in conjunction with supportive services.
- Youth handouts are intended to enhance communication, education, and support for youth/young adults, parents/caregivers, and community members, NOT replace it.

Capacity Building

The AHWG recognizes that this work is dependent on the involvement of providers, youth/young adults, and parents/caregivers across all sectors and systems. As a result, the AHWG will continue to focus its efforts on capacity building among health providers to meet the unique needs of youth and young adults, in addition to assisting with the development of supports for providers across other sectors and systems. Please contact the AHWG to inquire about possible collaboration opportunities. Current contact info can be accessed at www.ahwg.net

Suggested Citation

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PARTICIPATING ORGANIZATIONS

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- Instituto Familiar de la Raza
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Dedicated to:

Jeff & Lyla St. Andrews

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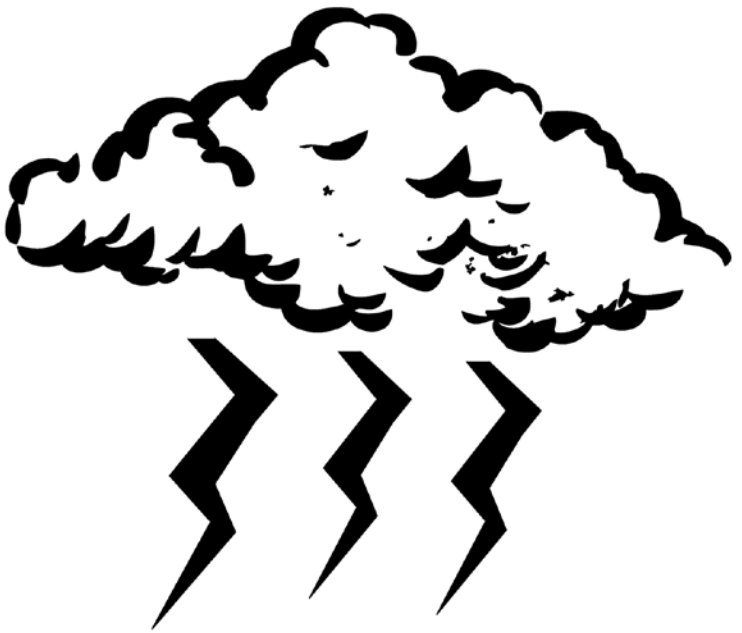
1. TRAUMA

2. RESILIENCE

3. CARE

▲ FOR YOUTH: Youth handouts specifically designed for youth/young adults are starred and underlined. Youth handouts may also be useful with parents/caregivers and community members, as deemed appropriate by providers, and in conjunction with supportive services. Youth handouts are intended to enhance communication, education, and support for youth/young adults, parents/caregivers, and community members, NOT replace it.

TRAUMA



KEY FACTS ON TRAUMA

THE TRAUMA EQUATION: TRAUMA = THE SUM OF EVENTS, EXPERIENCE, AND EFFECTS (1)

EVENTS

+ Events or circumstances may include the actual or extreme threat of physical or psychological harm or the severe withholding of resources for healthy development.
+ Events may occur once or repeatedly over time.

EXPERIENCE

+ An event may be experienced as traumatic by one individual and not another.
+ The experience may be influenced by cultural beliefs and the developmental stage of the individual.

EFFECTS

+ Adverse effects may occur immediately or over time.
+ Effects may include physical, mental, emotional, cognitive, behavioral, social, and spiritual challenges.
+ Individuals may not recognize the connection between effects and events.

TRAUMA IN THE CONTEXT OF COMMUNITY

- Trauma occurs in the context of community including:

  1) Neighborhoods: shared identity, culture, ethnicity, socioeconomic status, or experience, and 2) Organizations: place of work, learning, or worship.
- How a community responds to individual trauma sets the foundation for the impact of the traumatic events, experience, and effects.
- Communities that provide understanding, support, and self-determination may facilitate the healing and recovery process for the individual.
- Communities that avoid, overlook, or misunderstand the impact of trauma may often re-traumatize the individual and interfere with the healing process.

TRAUMA AND THE COLLECTIVE COMMUNITY EXPERIENCE

- Similar to an individual, a community may be subjected to a threatening event, share an experience of the event, and have adverse prolonged effects.
- Resulting trauma is often transmitted from one generation to the next in a pattern referred to as historical, community, or intergenerational trauma.
- Communities can collectively experience trauma similarly to the ways in which individuals respond to trauma.

TRAUMA-INFORMED CARE IS AS MUCH ABOUT SOCIAL JUSTICE AS IT IS ABOUT HEALING

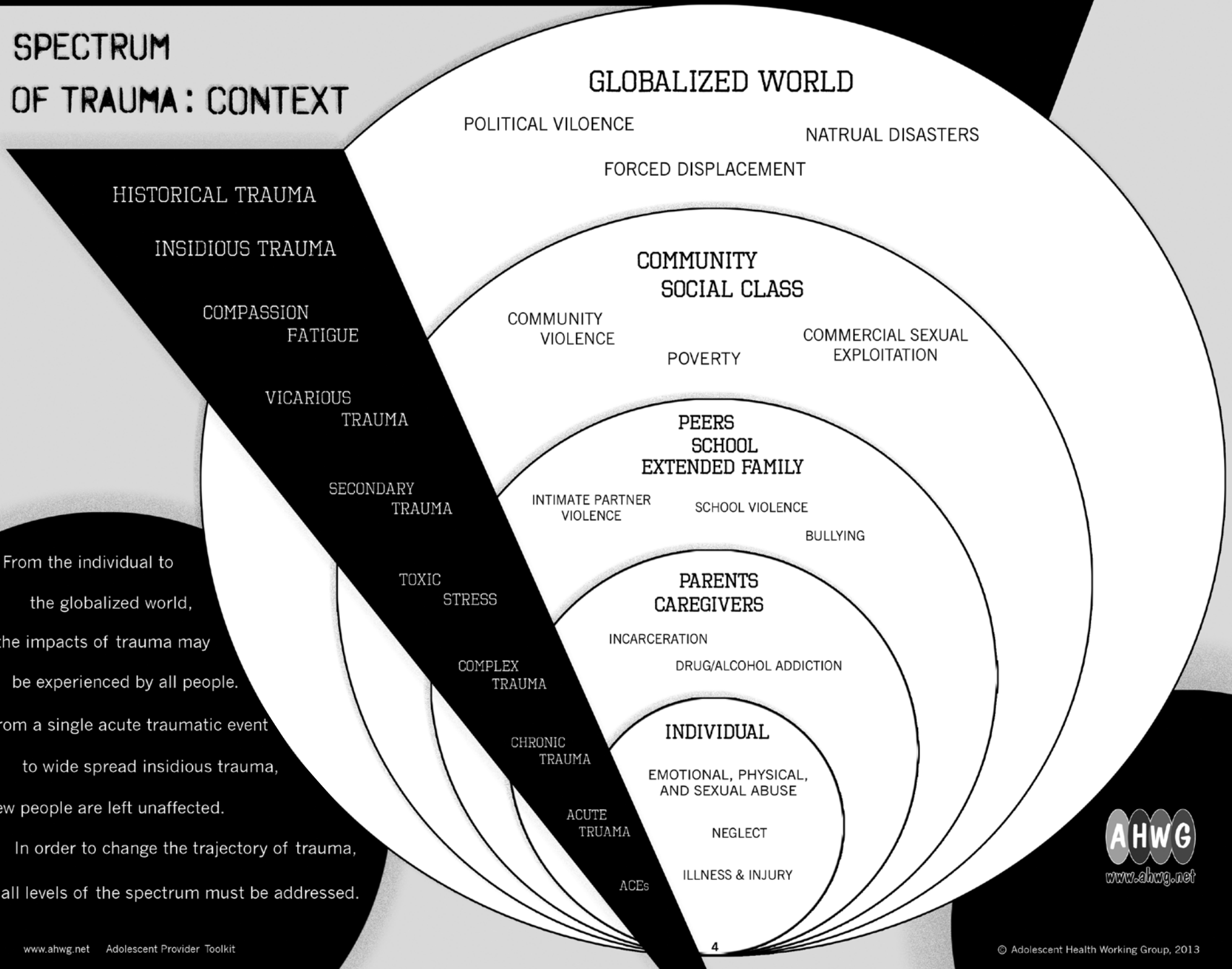
- The earlier in life trauma occurs, the more damaging the consequences may be.
- Prevention and early intervention of traumatic events and resulting consequences are critical.
- People are resilient and can recover from even severe trauma.
- With services, support, and resilience, healing is possible.

Sources: 1. Substance Abuse and Mental Health Services Administration (SAMHSA). 2012. Trauma Definition Working Draft. http://www.samhsa.gov/traumajustice/traumadefinition/index.aspx.
2. National Association of State Mental Health Program Directors (2012, September). Changing Communities, Changing Lives. Report prepared for the Substance Abuse and Mental Health Services Administration's National Center for Trauma-Informed Care. Alexandria, VA: (Joan Gillece, Project Director; Andrea Blanch, Author).

SPECTRUM OF TRAUMA : TERMINOLOGY

TERM	DEFINITION	EXAMPLES
Adverse Childhood Exeriences (ACEs) (2) 	Single or multiple traumatic exposures and/or events experienced during childhood.  	• Child physical abuse, sexual abuse, or emotional abuse • Child physical or emotional neglect • Mentally ill, depressed, or suicidal person in the home • Drug addicted or alcoholic family member • Witnessing domestic violence against the mother • Loss of a parent to death or abandonment in the context of divorce or separation • Incarceration of any family member
Acute Trauma (3)	A single, time-limited traumatic event.	• Physical maltreatment, abuse, assault • Sexual maltreatment, abuse, assault, rape • Emotional abuse, psychological maltreatment • Neglect • Natural disasters, war, terrorism, political violence • Kidnapping, human trafficking, commercial sexual exploitation • Forced displacement (refugees, political asylees) • Intimate partner violence, community violence, school violence • Bullying, harassment • Injuries, accidents • Illness, painful medical procedures • Severely impaired caregiver • Abandonment, betrayal of trust by primary caregiver • Traumatic loss, bereavement • Accumulated burdens of family's severe economic hardship • Homelessness
Chronic Trauma (3)	Multiple traumatic exposures and/or events over extended periods of time.	
Complex Trauma (4) **and Polyvictimization** (5)	Children/adolescent's experiences of multiple traumatic events and the impact of exposure to these events, often occurring within the care giving system.	
Toxic Stress (6)	Adverse experiences that lead to strong, frequent, or prolonged activation of the body's stress response system.	
Secondary Trauma (7) **and Vicarious Trauma** (8)	Exposure to the trauma of others as experienced, realized, or imagined by providers, family members, partners, or friends in close contact with traumatized individual.	
Compassion Fatigue (9)	Cumulative physical, emotional, and psychological effects of exposure to traumatic stories or events when working in a helping capacity.	
Insidious Trauma (10) **and Historical Trauma** (11)	Collective, massive group trauma and compounding forms of multiple oppressions including discrimination based on race, economic status, gender, sexuality, and immigration status, as experienced over extended periods of time, within societies and institutions.	• Colonialism • Genocide • Slavery • Poverty • Internment

SPECTRUM OF TRAUMA: CONTEXT



From the individual to the globalized world, the impacts of trauma may be experienced by all people. From a single acute traumatic event to wide spread insidious trauma, few people are left unaffected. In order to change the trajectory of trauma, all levels of the spectrum must be addressed.

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TRAUMA INEQUITIES

SOCIAL DETERMINANTS OF HEALTH

- Youth living in poverty are most likely to be exposed to trauma experiences, both at home and in the community.
- Roughly three times as many African-American, Hispanic, and American Indian/Alaska Native children live in poverty compared to White and Asian-American children.
- Poverty is a greater problem for minority ethno-cultural groups that have historically been subjected to political and cultural trauma in the US and in their families' countries of origin.
- Asian-American children and their families who are immigrants from impoverished and violence-torn countries are more vulnerable to violence as a result of racism and the scars of historical trauma.
- Other groups at high risk for exposure to violence in childhood include: urban and rural poor, tribal communities, lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth and adults; children and parents with physical disabilities or mental illness and addictions; and homeless individuals and families.(12)

CRADLE TO PRISON PIPELINE

- African American boys born in 2001 have a 1 in 3 chance of being imprisoned in thier lifetimes.(13)
- Latino boys born in 2001 have a 1 in 6 chance of being imprisoned in their lifetimes.(13)
- Arrest rates of trauma-exposed youth are up to 8 times higher than community samples of same-age peers.(14,15)
- Being abused or neglected as a child increases the likelihood of arrest as a juvenile by 59%.(16)
- 70%-92% of incarcerated girls report sexual, physical, or severe emotional abuse in childhood.(17,18)
- 70% of youth in residential placement have some type of past traumatic experience, with 30% having experienced frequent and/or injurious physical and/or sexual abuse.(19)

SUBSTANCE ABUSE

- Trauma increases the risk of developing substance abuse, and substance abuse increases the likelihood that adolescents will experience trauma.
- Up to 59% of youth with Post Traumatic Stress Disorder (PTSD) subsequently develop substance abuse problems.
- In surveys of adolescents receiving treatment for substance abuse, more than 70% had a history of trauma exposure. (20)
- Traumatic stress/PTSD may make it more difficult for adolescents to stop using, as exposure to reminders of traumatic events have been shown to increase drug cravings in people with co-occurring trauma and substance abuse. (20)
- Youth who are already abusing substances may be less able to cope with traumatic events as a result of the functional impairments associated with problematic use.
- Youth with both substance abuse and trauma exposure show more severe and diverse clinical problems than do youth who have been afflicted with only one of these problems.
- When trauma and substance abuse are treated separately, youth are more likely to relapse and revert to previous maladaptive coping strategies.(20)

TRAUMA EVIDENCE

ADVERSE CHILDHOOD EXPERIENCES (ACEs) STUDY (2)

Kaiser Permanente and Centers for Disease Control and Prevention, 1998

The Study:

17,000 mostly white, college-educated, employed adults were screened for 10 prominent childhood traumatic experiences as part of their routine health care at Kaiser. Participants received one point for each type of trauma.

The Results:

- 70% of the 17,000 people experienced at least one type of trauma, resulting in an "ACE score" of one; 87% of those had more than one.
- ACE scores of 4 or more resulted in four times the risk of emphysema or chronic bronchitis; over four times the likelihood of depression; and 12 times the risk of suicide.
- ACE scores were also directly correlated with early initiation of smoking and sexual activity, adolescent pregnancy, and risk for intimate partner violence.
- Eighteen states have since conducted ACE surveys with similar results.

NATIONAL SURVEY OF CHILDREN EXPOSED TO VIOLENCE (NATSCEV) (21)

Department of Justice and Centers for Disease Control and Prevention, 2009

The Study:

Over 4,500 children and youth from birth to age 17 were surveyed in the first attempt to measure the cumulative exposure to violence over a young person's lifetime, including violence in the home, school, and community.

The Results:

- Over 60% of children were exposed to violence in a year.
- Nearly half (46%) experienced a physical assault.
- 30% witnessed an assault in their community.
- 20% witnessed an assault in their family.
- 6% experienced sexual victimization.
- Over 38% were victimized two or more times.
- Over 10% were victimized five or more times.

Trauma Screening and Re-traumatization: Why Answering Questions About Trauma May Be Less Distressing Than Waiting in Line At The Bank (22)

University of New Mexico, 2012

The Study:

Over 500 undergraduate college students were randomly assigned to take a standardized intelligence test or to answer questions about trauma and sex, for two hours.

The Results:

- Participants who completed the trauma/sex survey reported slightly higher negative emotion on average than the intelligence-test participants, but the difference was very small, and the average level of negative emotion in both conditions was very low.
- Participants who completed the trauma/sex survey reported more positive emotion, more personal insight, less boredom, and less mental exhaustion.
- Participants in both conditions reported that the two-hour study was significantly less distressing than all 15 ordinary life events, including getting a paper cut, or waiting in line for 20 minutes at a bank.

COMPASSION FATIGUE:

INCLUDES: 1) PROVIDER BURNOUT, AND 2) SECONDARY TRAUMA/VICARIOUS TRAUMA

BURNOUT

- State of physical, emotional and mental exhaustion caused by long-term involvement in emotional demanding situations. (23)
- Associated with feelings of hopelessness and difficulties in dealing with work or doing one's job effectively. (24)

SECONDARY TRAUMA/VICARIOUS TRAUMA

- Work-related, secondary exposure to extremely or traumatically stressful events.
- Can be the result of the exposure of helpers to experiences of clients, in tandem with empathy experienced for clients. (25)
- Can be sudden and acute.

VICARIOUS TRAUMATIZATION

- A transformation in the helper's inner experience, as a result of empathic engagement with traumatized clients and their traumatic experiences, coupled with a commitment or responsibility to help. (26)

SIGNS AND SYMPTOMS OF VICARIOUS TRAUMATIZATION (27)

General Symptoms

- Numbing
- Social withdrawl
- Nightmares
- Despair and hopelessness
- No time or energy for self
- Disconnection from loved ones
- Increased sensitivity to violence

Internal Transformations

1. A Shifted Frame of Reference: Identity, spirituality, and worldview (e.g. questions goodness of others, loss of hope or optimism).
2. Diminished Self-Capacities: Capacity to tolerate strong emotion, and maintain connection with self and others.
3. Alterations in Sensory and Memory Experiences: Client's memories become incorporated into helper's memory.
4. Disrupted Psychological Needs: Safety, trust, esteem, intimacy, control.
5. Lessened Ego Resources/Internal Resources: Ability to establish and maintain boundaries, ability to strive for personal growth, ability to be introspective, awareness of psychological needs, clear cognitive processing, perspective, empathy, and sense of humor.

Impact on Organizations

- Colleagues experiencing vicarious trauma may treat each other with acts of unkindness, discourtesy, sabotage, infighting, lack of cohesiveness, scape-goating, bullying, and criticism among colleagues within and between affiliated organizations, a phenonmenon referred to as "horizontal violence." (28)

Assessment

- The Professional Quality of Life Scale (ProQOL) is the most commonly used measure of the negative and positive affects of helping others who experience suffering and trauma. The ProQOL has sub-scales for compassion satisfaction, burnout, and compassion fatigue. See: http://www.proqol.org/ProQol_Test

Source: Joyce Dorado, (2013). Self-Care for Educators: Coping with Stress in School. UCSF Healthy Environment and Response to Trauma in Schools (HEARTS), Child and Adolescent Services, Dept. of Psychiatry, University of California, San Francisco.

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE (PROQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

3. _____
6. _____
12. _____
16. _____
18. _____
20. _____
22. _____
24. _____
27. _____
30. _____

Total: _____

The sum of my Compassion Satisfaction questions is	So My Score Equals	And my Compassion Satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score

You Wrote	Change to
	5
2	4
3	3
4	2
5	1

*1. _____ = _____
*4. _____ = _____
8. _____
10. _____
*15. _____ = _____
*17. _____ = _____
19. _____
21. _____
26. _____
*29. _____ = _____

Total: _____

The sum of my Burnout Questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Secondary Traumatic Stress Scale

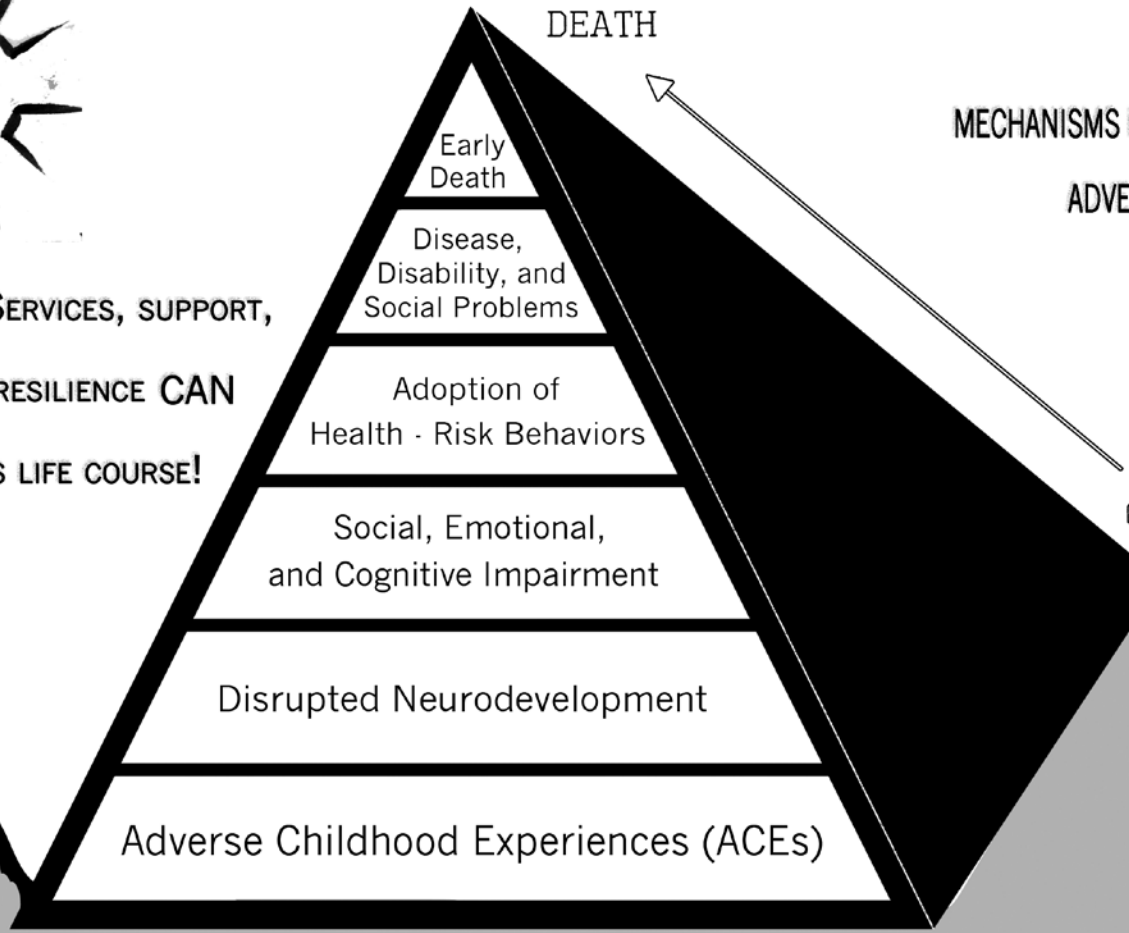
Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

2. _____
5. _____
7. _____
9. _____
11. _____
13. _____
14. _____
23. _____
25. _____
28. _____

Total: _____

The sum of my Secondary Trauma questions is	So My Score Equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

ACEs Pyramid[29]: The Origins of Risk Factors



MECHANISMS BY WHICH

ADVERSE CHILDHOOD EXPERIENCES (ACEs)

INFLUENCE HEALTH AND WELL-BEING

THROUGHOUT THE LIFE-SPAN

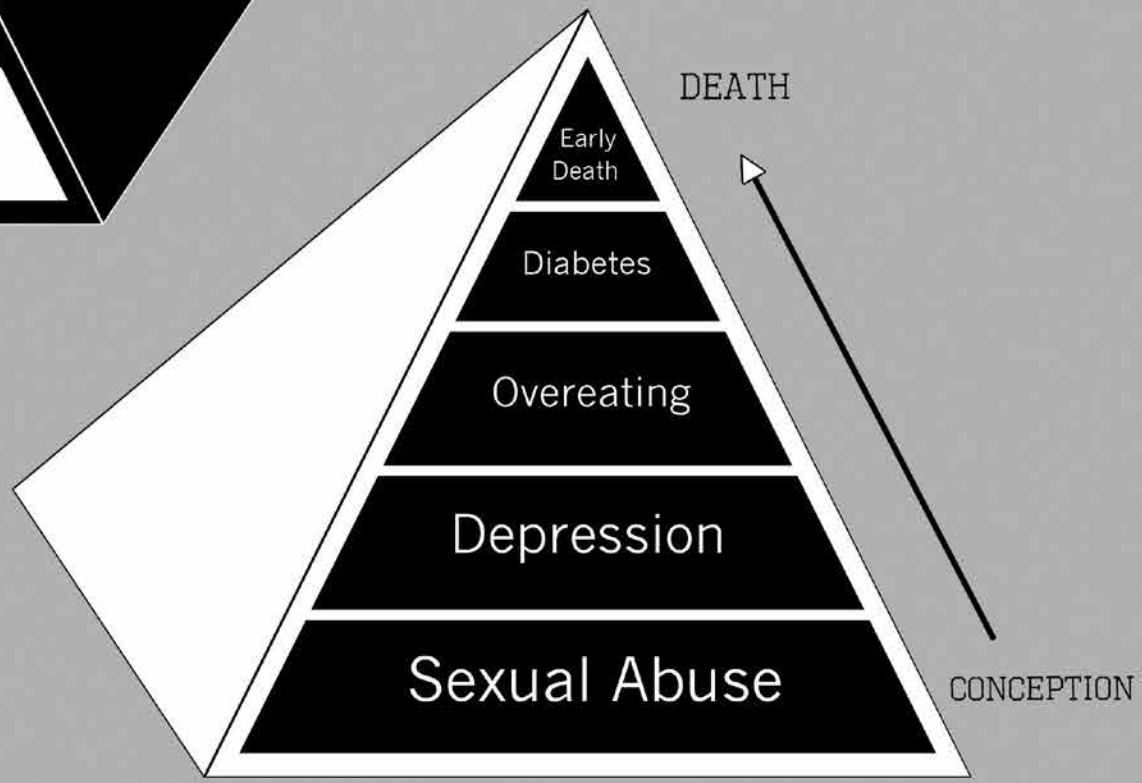
SERVICES, SUPPORT,

AND RESILIENCE CAN

CHANGE THIS LIFE COURSE!

ACEs Pyramids:[29]

REAL LIFE SCENARIOS



SERVICES, SUPPORT, AND RESILIENCE CAN CHANGE THIS LIFE COURSE!

HEALTH RISK BEHAVIORS:

MALADAPTIVE COPING STRATEGIES FOR ADVERSE CHILDHOOD EXPERIENCES (ACEs)

SEEKING TO COPE

- Health risk behaviors underlying adult diseases may actually function as effective coping strategies during adolescence.(30)
- Health risk behaviors may not be viewed by youth as the problem, they might be the youth's solution, a way to feel safe, reduce tension, and feel better, OR the youth may be completely unaware of what drives ACE-related behaviors, compulsions, or reactions.
- Dismissing maladaptive coping strategies as "bad habits" or "self destructive" misses their function.
- Maladaptive coping strategies need to be investigated, linked to previous ACEs, and adapted into positive coping strategies and behaviors.

ADVERSE CHILDHOOD EXPERIENCES (ACES) (2)

Abuse of Child Under Age 18

- Emotional Abuse
- Physical Abuse
- Sexual Abuse

Neglect of Child Under Age 18

- Physical neglect
- Emotional neglect

Household Environment

- Alcohol or drug user in home
- Chronically depressed, emotionally disturbed, or suicidal household member
- Mother treated violently
- Imprisoned household member
- Parents separated or divorced

EFFECTS OF TRAUMA AND RELATED HEALTH RISK BEHAVIORS(2)

Neurobiologic Effects of Trauma

- Disrupted neuro-development
- Difficulty controlling anger, rage
- Hallucinations
- Depression
- Anxiety
- Panic reactions
- Multiple (6+) somatic problems
- Sleep problems
- Impaired memory
- Flashbacks
- Dissociation

Health Risk Behaviors Used to Ease the Pain of Trauma

- Smoking
- Physcial inactivity
- Eating disorders
- Alcoholism
- Drug abuse
- Suicide attempts
- Self injury
- 50+ sexual partners
- Repitition of original trauma
- Perpetrate interpersonal violence

LONG-TERM CONSEQUENCES OF UNADDRESSED TRAUMA (ACES)(2)

Disease and Disability

- Cancer
- Ischemic heart disease
- Chronic lung disease
- Chronic emphysema
- Asthma
- Liver disease
- Severe obesity
- Skeletal fractures
- Poor self rated health
- Sexually transmitted infections
- HIV/AIDS

Serious Social Issues

- Homelessness
- Commercial sex work
- Delinquency, violence, criminal activity
- Inability to sustain employment
- Re-victimization: domestic violence, rape, bullying
- Long-term use of multiple human service systems
- Compromised ability to parent
- Intergenerational trauma

Source: Ann Jennings, PhD. www.theannainstitute.org

ADVERSE CHILDHOOD EXPERIENCES (ACEs) 10 QUESTION SCREENING TOOL

The ACEs 10 Question Screening Tool is an abbreviated version of the ACEs Family Health History Questionnaires and Health Appraisal Questionnaires available at: http://www.cdc.gov/ace/questionnaires.htm

A comprehensive list of validated youth trauma screening and assessment tools are maintained on the NCTSN Measures Review available at: http://www.nctsn.org/resources/online-research/measures-review

FINDING YOUR ACEs SCORE

WHILE YOU WERE GROWING UP, DURING YOUR FIRST 18 YEARS OF	Circle	One	If YES Enter 1
1. Did a parent or other adult in the household **often or very often** swear at you, insult you, put you down, or humiliate you? **OR** act in a way that made you afraid that you might be physically hurt?	Yes	No	
2. Did a parent or other adult in the household **often or very often** push, grab, slap, or throw something at you? **OR** ever hit you so hard that you had marks or were injured?	Yes	No	
3. Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way? **OR** attempt or actually have oral, anal, or vaginal intercourse with you?	Yes	No	
4. Did you **often or very often** feel that: No one in your family loved you or thought you were important or special? **OR** your family didn't look out for each other, feel close to each other, or support each other?	Yes	No	
5. Did you **often or very often** feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **OR** your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	Yes	No	
6. Were your parents ever separated or divorced?	Yes	No	
7. Was your mother or stepmother **often or very often** pushed, grabbed, slapped, or had something thrown at her? **OR** sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? **OR** ever repeatedly hit at least a few minutes or threatened with a gun or knife?	Yes	No	
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	Yes	No	
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?	Yes	No	
10. Did a household member go to prison?	Yes	No	
NOW ADD UP YOUR "YES" ANSWERS. THIS IS YOUR ACEs SCORE.			

Source: http://acestoohigh.com/got-your-ace-score/

ADOLESCENT BRAIN DEVELOPMENT

Brain Function: Manages cognitive, emotional, behavioral, and physical functioning.

Brain System: Made up of interconnecting systems that go from least complex (brainstem: mediates heart rate) to most complex (frontal lobe: the main decision maker of the brain).

Brain Growth: 2 major growth spurts: 1) in the womb, and 2) between childhood and adolescence.

IMPORTANT: Brain development is **NOT** complete until mid to late 20's.

Neurons that Fire Together Wire Together (Hebb's Rule): Brain neurons synapse (i.e. connect with other neurons) or change (chemically and structurally) in response to signals from the environment (experiences) and create memories (cognitive, emotional, behavioral, and physical). The more often neural connections are made, the stronger these connections become.

Synaptic Pruning: During adolescence, the brain begins to break down the least used synapses, or connections and strengthens those most used.

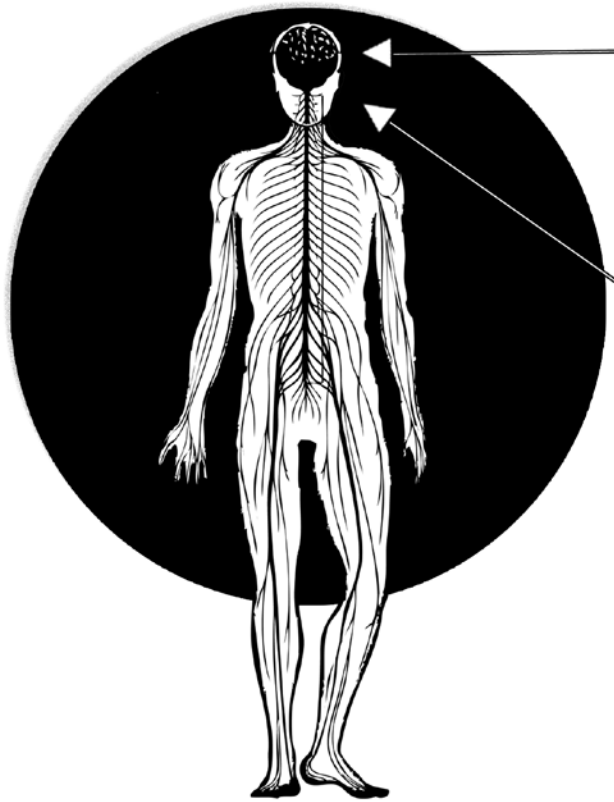
MOST COMPLEX

Frontal Lobe

Abstract Thought
Concrete Thought
Affiliation
Attachment
Sexual Behavior
Emotional Reactivity
Motor Regulation
Arousal
Appetite
Sleep
Blood Pressure
Heart Rate
Body Temperature

Brainstem

LEAST COMPLEX



HIGHER FUNCTIONS

Frontal Lobe

Learning Brain: thinking, planning, decision-making
Impulse and behavior control
Undergoing development in youth ages 10-24

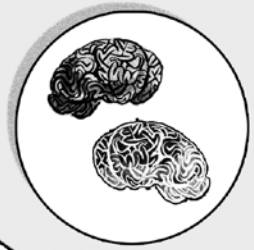
LOWER FUNCTIONS

Brainstem

Survival Brain: flight, flight, or freeze
Emotion-driven processing
Heavily relied on by youth

Source: Dorado, J. 2013. Promoting School Success for Students Who Have Experienced Complex Trauma: Creating Trauma-Sensitive School Environments. Healthy Environments and Response to Trauma in Schools (HEARTS), University of California San Francisco (UCSF).

SURVIVAL BRAIN VS. LEARNING BRAIN



ALARM SYSTEM: We all have normal alarm systems in our brain/body that lets us know when we are under threat and mobilizes us to fight, flight, or flee threat. When youth experience continuous threats/trauma, the brain/body is put into a chronic state of fear, activating the "survival brain" (mid/lower areas of the brain). This can create an overactive alarm system in the developing brain. A youth's brain/body that develops within the context of trauma can be more easily triggered into "survival brain" by "trauma reminders" or "triggers" even when there is no actual threat. (32,33)

TRAUMA TRIGGERS: Can activate the "survival brain," causing youth to react as though a "there and then" experience (previous traumatic event) is happening "here and now" (in current reality).

Common triggers include:

- Unpredictability
- Sudden changes or transitions
- Loss of control
- Sensory overload
- Feeling vulnerable
- Rejection
- Loneliness
- Confrontation
- Intimacy
- And even praise or positive attention

When youth are in a triggered state, they may not be able to access higher functions of the frontal lobe ("learning brain"). At this time, verbal warnings of consequences, or making demands on the higher "learning brain" (i.e. asking them to explain their decision-making process), may escalate the situation.

DE-ESCALATION: Youth in a triggered state need help to calm down from "there and then" triggers and become more present in "here and now" reality, (in which there may be no actual threat). Feelings of safety and control must be re-established in order for youth to think more clearly.

Strategies include:

- Noticing signs of distress
- Connecting with the youth
- And then re-directing behavior through providing reasonable choices/options for alternative activities/circumstances
- After youth is calm, discussion about what happened can take place and if necessary, consequences can be determined

The long-term goal is NOT to turn off the brain/body alarm system, as the alarm is needed to detect ongoing/real threats. The goal is to increase the alarm's accuracy so that it doesn't turn on unnecessarily.

BRAIN PLASTICITY: Patterned, repetitive activities can help the brain to re-wire and organize itself into more healthy functioning. Activities may include: music, movement, drumming, yoga, deep breathing, mindfulness, and positive, nurturing interactions with trustworthy adults and peers. (32)

Source: Dorado, J. 2013. Promoting School Success for Students Who Have Experienced Complex Trauma: Creating Trauma-Sensitive School Environments. Healthy Environments and Response to Trauma in Schools (HEARTS), University of California San Francisco (UCSF).

NEUROBIOLOGICAL RESPONSE SYSTEMS

STRESS RESPONSE: POSITIVE, TOLERABLE, OR TOXIC (33)

POSITIVE STRESS RESPONSE

- Normal and essential part of healthy development.
- Includes brief increases in heart rate and mild elevations in hormone levels.

Examples: Attending a new school; going out with new friends.

TOLERABLE STRESS RESPONSE

- Activates the mind/body alarm system as a result of more severe, longer-lasting difficulties.
- If activation is time-limited and buffered by relationships with caring adults who help youth to adapt, the brain and other organs may recover from possible damaging effects.

Examples: Loss of a loved one; natural disaster; frightening injury.

TOXIC STRESS RESPONSE

- Can occur when youth experiences strong, frequent, and/or prolonged adversity.
- Without adequate adult support, prolonged activation of the stress response system can disrupt the development of brain architecture and other organs
- Risk for stress-related disease and cognitive impairment is increased well into adulthood.

Examples: Physical or emotional abuse; chronic neglect; caregiver substance abuse or mental illness; exposure to violence; accumulated burdens of severe family economic hardship.

SURVIVAL RESPONSE: FIGHT, FLIGHT, OR FREEZE (34-36)

FIGHT

- Youth struggle to regain or hold on to power, especially when feeling coerced.

Youth often mislabeled as: Non-compliant or combative.

FLIGHT

- Youth disengages or runs away and "checks out" emotionally.

Youth often mislabeled as: Uncooperative or resistant.

FREEZE

- Youth gives in to those in positions of power; does not, or is unable to "speak up."

Youth often mislabeled as: Passive or unmotivated.

CHRONIC TRAUMA

AFFECTS THE WHOLE YOUTH

EMOTIONAL

Terror/fear
Sadness
Shock
Loss of pleasure from activities
Despair
Emotional numbering
Hypersensitivity
Helplessness
Depression
Irritability
Guilt
Grief
Phobias
Anger

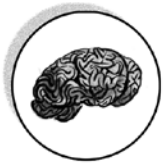
PHYSICAL

Sleep disturbance
Startle response
Somatic complaints
Insomnia
Impaired immune response
Gastrointestinal problems
Decreased appetite
Hyperarousal
Decreased libido
Headaches
Fatigue

INTERPERSONAL & BEHAVIORAL

Aggression
Regression in behavior
Crying easily
Risk taking
Social withdrawl
Change in eating patterns
Alienation
Avoiding trauma reminders
Tantrums
School impairment
Refusal to go back to school
Increased relationship conflict
Vocational impairment
Isolation

CONGNITIVE



Worry
Nightmares
Confusion
Disbelief
Memory impairment
Impaired decision making ability
Impaired concentration
Decreased self-efficancy
Self blame
Distortion
Decreased self-esteem
Intrusive thoughts/ memories

POST TRAUMATIC STRESS DISORDER (PTSD)

Post Traumatic Stress Disorder (PTSD) is the leading diagnosis available in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-IV) for post traumatic symptoms among youth and adults. (37)

PTSD is an important diagnosis, however it is limited by the following: (38)

- Originally developed for and is most relevant to adults, not children/youth.
- More often captures symptoms of single/acute traumatic events, not complex/chronic traumatic events.
- Focuses on the individual.

PTSD A: Stressor

The person has been exposed to a traumatic event in which both of the following have been present:

1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.
2. The person's response involved intense fear, helplessness, or horror. Note: in children, it may be expressed instead by disorganized or agitated behavior.

PTSD B: Intrusive Recollection

The traumatic event is persistently re-experienced in at least one of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.

Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

2. Recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content.
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: In children, trauma-specific reenactment may occur.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

PTSD C: Avoidant/Numbing

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
3. Inability to recall an important aspect of the trauma.
4. Markedly diminished interest or participation in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect (e.g., unable to have loving feelings).
7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

PTSD D: Hyper-Arousal

Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least two of the following:

1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hyper-vigilance.
5. Exaggerated startle response.

PTSD E: Duration

Duration of the disturbance (symptoms in B, C, and D) is more than one month.

PTSD F: Functional Significance

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

Specify If: Acute: If duration of symptoms is less than three months; Chronic: if duration of symptoms is three months or more; With or Without delay onset: Onset of symptoms at least six months after the stressor.

BEYOND PTSD: DEVELOPMENTAL TRAUMA DISORDER

Developmental Trauma Disorder is a proposed diagnosis for the upcoming fifth edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-V) to capture more developmentally appropriate post traumatic symptoms specific to children/youth. (38)

Developmental Trauma Disorder Includes:

1) Child/youth specific and developmentally appropriate symptoms. 2) Complex/chronic trauma symptoms. 3) Role of impaired caregiving systems.

AFFECTIVE AND PHYSIOLOGICAL DYSREGULATION Impaired arousal regulation	• Inability to modulate, tolerate, or recover from extreme affect states (e.g fear, anger, shame) including prolonged and extreme tantrums, or immobilization. • Disturbances in regulation of bodily functions (e.g. sleeping, eating, and elimination; over-reactivity or under-reactivity to touch and sounds; disorganization during routine transitions). • Decreased awareness or dissociation of sensations, emotions, and bodily states. • Impaired capacity to describe emotions or bodily state.
ATTENTIONAL AND BEHAVIORAL DYSREGULATION Impaired attention, learning, and coping mechanisms	• Preoccupation with threat, or impaired capacity to perceive threat, including misreading of safety and danger cues. • Impaired capacity for self-protection, including extreme risk-taking or thrill-seeking. • Maladaptive attempts at self-soothing (e.g. rocking, other rhythmical movements, compulsive masturbation). • Habitual (intentional, automatic, or reactive) self-harm. • Inability to initiate or sustain goal-directed behavior.
SELF AND RELATIONAL DYSREGULATION Impaired sense of personal identity and involvement in relationships	• Intense preoccupation with safety of caregiver or loved ones, or difficulty tolerating reunion with them after separation. • Persistent negative sense of self (e.g. self-loathing, helplessness, worthlessness, ineffectiveness, or defectiveness). • Extreme and persistent distrust, defiance or lack of reciprocal behavior in close relationships with adults or peers. • Reactive physical or verbal aggression toward peers, caregivers, or other adults. • Inappropriate (excessive or promiscuous) attempts to get intimate contact (including but not limited to sexual or physical intimacy) or excessive reliance on peers or adults for safety and reassurance. • Impaired capacity to regulate empathic arousal (e.g. lack of empathy for, or intolerance of distress in others, or excessive responsiveness to the distress of others).
FUNCTIONAL IMPAIRMENT School, family, peer group, legal, health, and work impairments	• **School:** Under-performance, non-attendance, disciplinary problems, drop-out, failure to complete degree/credentials, conflict with school personnel, learning disabilities or intellectual impairment that cannot be accounted for by neurological or other factors. • **Family:** Conflict, avoidance/passivity, running away, detachment and surrogate replacements, attempts to physically or emotionally hurt family members, non-fulfillment of responsibilities within family. • **Peers:** Isolation, deviant affiliations, persistent physical or emotional conflict, avoidance/passivity, involvement in violence or unsafe acts, age inappropriate affiliations or style of interaction. • **Legal:** Arrests/recidivism, detention, convictions, incarceration, violation of probation/court orders, increasingly severe offenses, crimes against other persons, disregard or contempt for the law or for conventional moral standards. • **Health:** Physical illness or problems that cannot be fully accounted for, involving digestive, neurological, sexual, immune, cardiopulmonary, proprioceptive, sensory systems, severe headaches (including migraine), or chronic pain/fatigue. • **Work:** Youth involved in, seeking, or referred for employment, volunteer, or job training show disinterest in work/vocation, inability to get or keep jobs, persistent conflict with co-workers or supervisors, under-employment in relation to abilities, failure to achieve expectable advancements.

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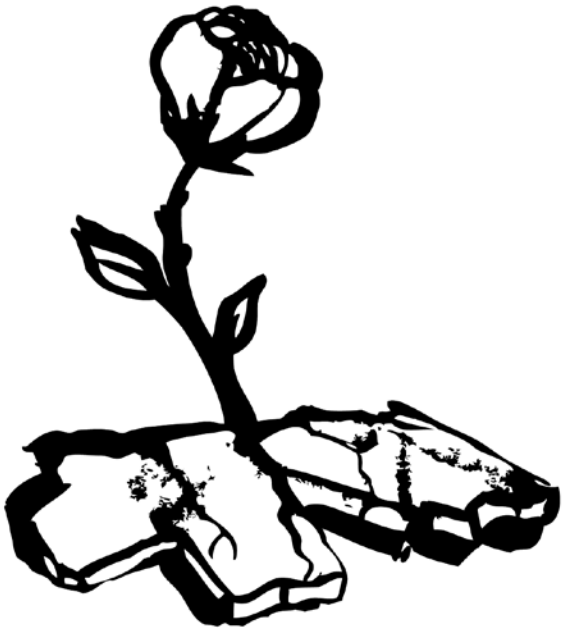
RESILIENCE



SPECTRUM OF RESILIENCE

RESILIENCE

- The positive capacity to cope, adjust to, or recover from stress and negative life events; includes personality traits, social skills, and responses that enable thriving in the face of adversity. (1-5)

- All people are born with resilience; it can be nurtured and recaptured if lost.

- Factors can be internal characteristics such as individual talents, energies, strengths, and constructive interests; or external influences like family support, adult role models outside the family, high expectations within the community, and the availability of creative activities.

POSTTRAUMATIC GROWTH

- 30%-90% of people affected by a serious crisis describe some type of posttraumatic growth. (8)

- Posttraumatic growth includes changes in perception of self, the improvement and deepening of relationships with others, a heightened compassion for others, an increased ability for expressing emotions, and an ability to find meaning in the trauma experienced.

VICARIOUS RESILIENCE/ (6) COMPASSION SATISFACTION (7)

- Compassion satisfaction includes the pleasure from being able to do one's work well, helping others through work, positive feelings about colleagues, and contributing to the work setting or greater good of society.

- Vicarious resilience is the process in which workers in helping professions may experience positive influences, such as hope and increased self-efficacy, through their work with trauma survivors.

RESILIENCE TRUMPS ACEs

ADVERSE CHILDHOOD EXPERIENCE (ACEs)

- ACEs are NOT a life sentence and they are NOT set in stone.
- There ARE ways to lessen the effects of ACEs.

RESILIENCE

- Responsive caregiving provided to youth from trusted adults can moderate the effects of early stress and neglect associated with ACEs.
- Building resilience can counter the effects of ACEs and help lead youth to more effective, productive, and healthy adulthoods.

BUILDING BLOCKS

- Resilience building blocks include simple actions, responses, and attitudes.
- Each block can look small and simple, but together form a solid foundation on which youth and adults can build the capacity to thrive, even when life poses inevitable hardships, challenges, and disappointments.

Adverse Childhood Experiences (ACEs)

- Sexual abuse
- Physical abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Loss of a parent/caregiver
- Witnessing family violence
- Incarceration of a family member
- Drug addicted or alcoholic family member
- Mentally ill, depressed, or suicidal family member

Source: Resilience Trumps ACEs (copyright). Children's Resilience Initiative. www.resiliencetrumpsaces.org

RESILIENCE BUILDING BLOCKS

FOR ADULTS

- Model appropriate behavior
- Model problem solving skills
- Set clear expectations and rules
- Establish consequences
- Teach youth self-discipline and responsibility
- Assign chores to give youth responsibility
- Have regular check-ins with youth
- Let youth know they are loved
- Let youth know you are available to help
- Help youth express their feelings
- Help youth develop problem-solving skills
- Help youth appreciate cultural and ethnic heritage
- Give youth choices
- Respect youth's ability to make decisions
- Allow youth's experience of success and failure

FOR YOUTH AND ADULTS

- Hope, trust, and a sense of belonging
- Attachment to a caring adult
- Ability to express feelings and calm oneself
- Learn to sense triggers that create negative behaviors and accept ownership of behaviors
- Learn responsibility, problem solving, and decision making
- Learn to ask for help and accept help
- Learn to show appreciation and empathy
- Learn to self-advocate and develop self-esteem
- Develop friendships and share something important
- Develop a sense of control
- Work as a team and give back to the community
- Master a skill and experience success

POSTTRAUMATIC GROWTH

Posttraumatic growth does NOT mean that pain or fear from trauma go away. Posttraumatic growth means that individuals are able to find meaning in the trauma, learn more about themselves in the process, and find opportunities to apply increased self-knowledge to making healthy life choices.

REQUIREMENTS FOR POSTTRAUMATIC GROWTH:(9)

A safe environment

- Since feelings of extreme danger and vulnerability are inherent to most traumatic experiences, establishing feelings of safety for youth is necessary before beginning to process the experience.

Listening without trying to solve

- Youth may feel angry or scared and express a variety of emotions in order to make sense of an experience.
- Caring adults must resist the urge to "make it all better," which may come from personal needs to make intense feelings more tolerable.

Recognizing and highlighting growth or changed perspective:

- Making note and commenting on a youth's new insights can help reinforce positive growth.

Reframing growth and opportunity

- There is a tendency to say that a traumatic experience caused growth. It may be more helpful to reframe and say that trauma didn't cause the growth but created an opportunity for growth.

Referrals for counseling, if appropriate

- Many youth don't know about, are afraid of, or have heard negative experiences about mental health services, however counseling can be a useful tool for youth in making sense out of life

POSTTRAUMATIC GROWTH INCLUDES:

- Changes in one's perception of self.
- Improvement and deepening of one's relationships with others.
- Heightened compassion for others.
- Increased ability to express emotions.

TIPS FOR POSTTRAUMATIC GROWTH: (10)

- Support appropriate interpersonal skills.
- Promote affect regulation (e.g. practicing coping skills such as self-soothing or distraction).
- Support autonomous decision-making and independent functioning.
- Foster spirituality through exploration of beliefs, attitudes and faith.
- Emphasize ability to make changes in the course of life.
- Nurture a clear and positive identity, encouraging identity exploration, and integrating different parts of self.
- Foster hope, belief in the future, goal-setting, and envisioning future plans.
- Recognize positive behavior, and celebrating healthy behavioral changes.
- Provide opportunities for pro-social involvement by creating time or space for positive interaction and community support.
- Establish pro-social norms by not tolerating destructive behavior, and normalizing positive interactions and healthy coping.

Source: Providing Trauma Informed Care for Homeless Youth: A Supervisor's Guide. Hollywood Homeless Youth Partnership. http://hhyp.org/download-material-2/

40 DEVELOPMENTAL ASSETS® FOR ADOLESCENTS (AGES 12-18)

Search Institute® has identified the following building blocks of healthy development—known as Developmental Assets®—that help young people grow up healthy, caring, and responsible.

EXTERNAL ASSETS

SUPPORT

1. Family support—Family life provides high levels of love and support.
2. Positive family communication—Young person and her or his parent(s) communicate positively, and young person is willing to seek advice and counsel from parents.
3. Other adult relationships—Young person receives support from three or more nonparent adults.
4. Caring neighborhood—Young person experiences caring neighbors.
5. Caring school climate—School provides a caring, encouraging environment.
6. Parent involvement in schooling—Parent(s) are actively involved in helping young person succeed in school.

EMPOWERMENT

7. Community values youth—Young person perceives that adults in the community value youth.
8. Youth as resources—Young people are given useful roles in the community.
9. Service to others—Young person serves in the community one hour or more per week.
10. Safety—Young person feels safe at home, school, and in the neighborhood.

BOUNDARIES AND EXPECTATIONS

11. Family boundaries—Family has clear rules and consequences and monitors the young person's whereabouts.
12. School Boundaries—School provides clear rules and consequences.
13. Neighborhood boundaries—Neighbors take responsibility for monitoring young people's behavior.
14. Adult role models—Parent(s) and other adults model positive, responsible behavior.
15. Positive peer influence—Young person's best friends model responsible behavior.
16. High expectations—Both parent(s) and teachers encourage the young person to do well.

CONSTRUCTIVE USE OF TIME

17. Creative activities—Young person spends three or more hours per week in lessons or practice in music, theater, or other arts.
18. Youth programs—Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in the community.
19. Religious community—Young person spends one or more hours per week in activities in a religious institution.
20. Time at home—Young person is out with friends "with nothing special to do" two or fewer nights per week.

INTERNAL ASSETS

COMMITMENT TO LEARNING

21. Achievement Motivation—Young person is motivated to do well in school.
22. School Engagement—Young person is actively engaged in learning.
23. Homework—Young person reports doing at least one hour of homework every school day.
24. Bonding to school—Young person cares about her or his school.
25. Reading for Pleasure—Young person reads for pleasure three or more hours per week

POSTIVE VALUES

26. Caring—Young person places high value on helping other people.
27. Equality and social justice—Young person places high value on promoting equality and reducing hunger and poverty.
28. Integrity—Young person acts on convictions and stands up for her or his beliefs.
29. Honesty—Young person "tells the truth even when it is not easy."
30. Responsibility—Young person accepts and takes personal responsibility.
31. Restraint—Young person believes it is important not to be sexually active or to use alcohol or other drugs.

SOCIAL COMPETENCIES

32. Planning and decision making—Young person knows how to plan ahead and make choices.
33. Interpersonal Competence—Young person has empathy, sensitivity, and friendship skills.
34. Cultural Competence—Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.
35. Resistance skills—Young person can resist negative peer pressure and dangerous situations.
36. Peaceful conflict resolution—Young person seeks to resolve conflict nonviolently.

POSITIVE IDENTITY

37. Personal power—Young person feels he or she has control over "things that happen to me."
38. Self-esteem—Young person reports having a high self-esteem.
39. Sense of purpose—Young person reports that "my life has a purpose."
40. Positive view of personal future—Young person is optimistic about her or his personal future.

ASSETS EVIDENCE

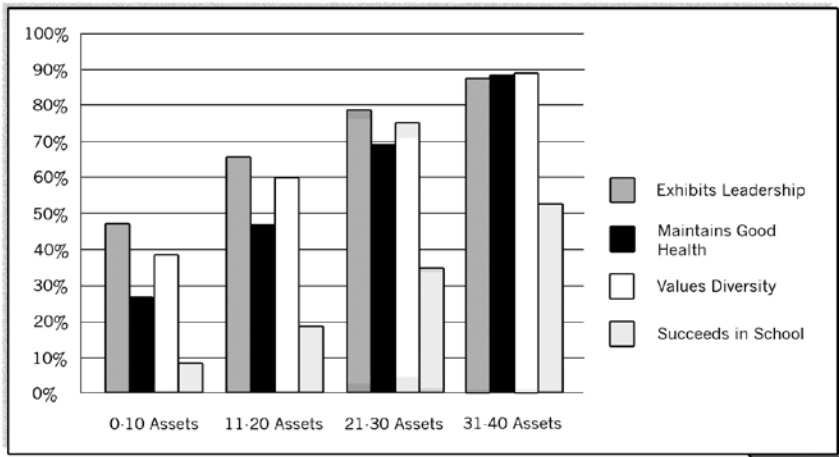
WHAT ARE THEY?

- Assets are common sense positive experiences and qualities that help influence choices young people make and help them become caring, responsible, successful adults.
- Based in youth development, resiliency, and prevention research, with proven effectiveness. (11)

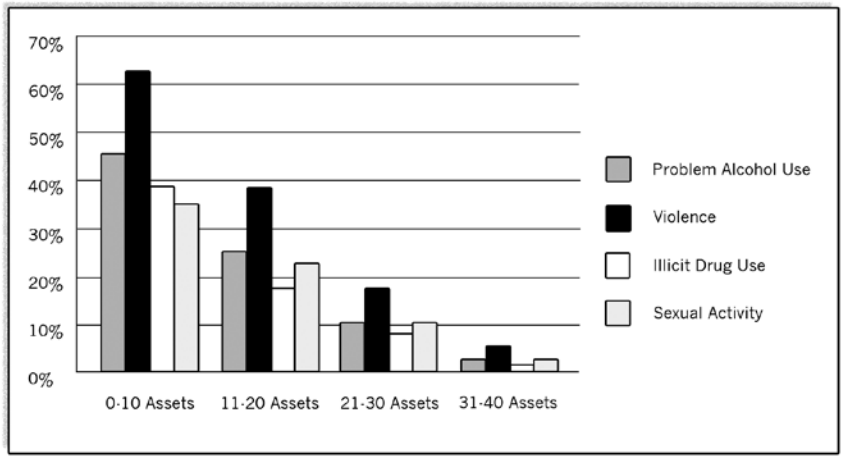
WHO NEEDS THEM?

- Studies of more than 2.2 million young people consistently show that the more assets young people have, the less likely they are to engage in a wide range of high-risk behaviors and the more likely they are to thrive. (11)
- Research has proven that youth with the most assets are least likely to engage in four different patterns of high-risk behavior, including problem alcohol use, violence, illicit drug use, and sexual activity.
- The same kind of impact is evident with many other problem behaviors, including tobacco use, depression and attempted suicide, antisocial behavior, school problems, driving and alcohol, and gambling.

ASSETS PROMOTE POSITIVE ATTITUDES AND BEHAVIORS



ASSETS PROTECT YOUTH FROM HEALTH RISK BEHAVIORS



THE POWER OF ASSETS

- The positive power of assets is evident across all cultural and socioeconomic groups of youth.
- In addition to protecting youth from negative behaviors, having more assets increases the chances that young people will have positive attitudes and behaviors. (11)

Source: Search Institute (copyright). http://www.search-institute.org/developmental-assets

DEVELOPMENTAL ASSETS PROFILE

Self-Report for Ages 11-18

NAME / ID: _____ **TODAY'S DATE:** Mo: _____ Day:_____ Yr:_____

SEX: ☐ Male ☐ Female **AGE:** _____ **GRADE:**_____ **BIRTH DATE:** Mo:_____ Day:_____ Yr:_____

RACE/ETHNICITY (Check all that apply): ☐ American Indian or Alaska Native ☐ Asian

☐ Black or African American ☐ Hispanic or Latino/Latina ☐ Native Hawaiian or Other Pacific Islander

☐ White ☐ Other (*please specify*):

INSTRUCTIONS: Below is a list of positive things that you might have in *yourself, your family, friends, neighborhood, school, and community*. For each item that describes you **now or within the past 3 months**, check if the item is true:

Not At All or Rarely **Somewhat or Sometimes** **Very or Often** **Extremely or Almost Always**

If you do not want to answer an item, leave it blank. But please try to answer all items as best you can.

Not At All or Rarely	Somewhat or Sometimes	Very or Often	Extremely or Almost Always	I . . .
☐	☐	☐	☐	1. Stand up for what I believe in.
☐	☐	☐	☐	2. Feel in control of my life and future.
☐	☐	☐	☐	3. Feel good about myself.
☐	☐	☐	☐	4. Avoid things that are dangerous or unhealthy.
☐	☐	☐	☐	5. Enjoy reading or being read to.
☐	☐	☐	☐	6. Build friendships with other people.
☐	☐	☐	☐	7. Care about school.
☐	☐	☐	☐	8. Do my homework.
☐	☐	☐	☐	9. Stay away from tobacco, alcohol, and other drugs.
☐	☐	☐	☐	10. Enjoy learning.
☐	☐	☐	☐	11. Express my feelings in proper ways.
☐	☐	☐	☐	12. Feel good about my future.
☐	☐	☐	☐	13. Seek advice from my parents.
☐	☐	☐	☐	14. Deal with frustration in positive ways.
☐	☐	☐	☐	15. Overcome challenges in positive ways.
☐	☐	☐	☐	16. Think it is important to help other people.
☐	☐	☐	☐	17. Feel safe and secure at home.
☐	☐	☐	☐	18. Plan ahead and make good choices.
☐	☐	☐	☐	19. Resist bad influences.
☐	☐	☐	☐	20. Resolve conflicts without anyone getting hurt.
☐	☐	☐	☐	21. Feel valued and appreciated by others.
☐	☐	☐	☐	22. Take responsibility for what I do.
☐	☐	☐	☐	23. Tell the truth even when it is not easy.
☐	☐	☐	☐	24. Accept people who are different from me.
☐	☐	☐	☐	25. Feel safe at school.

PLEASE TURN OVER AND COMPLETE THE BACK.

Note: The term "Parent(s)" means 1 or more adults who are responsible for raising you.

Not At All or Rarely	Somewhat or Sometimes	Very or Often	Extremely or Almost Always	
				I AM . . .
☐	☐	☐	☐	26. Actively engaged in learning new things.
☐	☐	☐	☐	27. Developing a sense of purpose in my life.
☐	☐	☐	☐	28. Encouraged to try things that might be good for me.
☐	☐	☐	☐	29. Included in family tasks and decisions.
☐	☐	☐	☐	30. Helping to make my community a better place.
☐	☐	☐	☐	31. Involved in a religious group or activity.
☐	☐	☐	☐	32. Developing good health habits.
☐	☐	☐	☐	33. Encouraged to help others.
☐	☐	☐	☐	34. Involved in a sport, club, or other group.
☐	☐	☐	☐	35. Trying to help solve social problems.
☐	☐	☐	☐	36. Given useful roles and responsibilities.
☐	☐	☐	☐	37. Developing respect for other people.
☐	☐	☐	☐	38. Eager to do well in school and other activities.
☐	☐	☐	☐	39. Sensitive to the needs and feelings of others.
☐	☐	☐	☐	40. Involved in creative things such as music, theater, or art.
☐	☐	☐	☐	41. Serving others in my community.
☐	☐	☐	☐	42. Spending quality time at home with my parent(s).
				I HAVE . . .
☐	☐	☐	☐	43. Friends who set good examples for me.
☐	☐	☐	☐	44. A school that gives students clear rules.
☐	☐	☐	☐	45. Adults who are good role models for me.
☐	☐	☐	☐	46. A safe neighborhood.
☐	☐	☐	☐	47. Parent(s) who try to help me succeed.
☐	☐	☐	☐	48. Good neighbors who care about me.
☐	☐	☐	☐	49. A school that cares about kids and encourages them.
☐	☐	☐	☐	50. Teachers who urge me to develop and achieve.
☐	☐	☐	☐	51. Support from adults other than my parents.
☐	☐	☐	☐	52. A family that provides me with clear rules.
☐	☐	☐	☐	53. Parent(s) who urge me to do well in school.
☐	☐	☐	☐	54. A family that gives me love and support.
☐	☐	☐	☐	55. Neighbors who help watch out for me.
☐	☐	☐	☐	56. Parent(s) who are good at talking with me about things.
☐	☐	☐	☐	57. A school that enforces rules fairly.
☐	☐	☐	☐	58. A family that knows where I am and what I am doing.

THANK YOU FOR COMPLETING THIS FORM.

ATTACHMENT, SELF-REGULATION, AND COMPETENCY (ARC)[12]

ARC: A Conceptual framework and core intervention principles for working with youth who have experienced multiple and/or prolonged traumas. Can be used in: 1) Clinical work with youth, 2) Provider team meetings, and 3) Administrative review of agency policies and procedures.

ATTACHMENT: The capacity to form and maintain a healthy emotional bond with another person as a source of mutual comfort, safety, and caring.

SELF-REGULATION: Developing and maintaining the ability to identify, express, and modulate feelings such as frustration, anger, and fear.

COMPETENCY: Mastering the developmental tasks of adolescence and developing the ability to plan and organize for the future. Areas of competency include: judgment, impulse control, planning, prioritizing tasks, organizing, insight, empathy, and decision-making. Competency also includes specific life skills such as: hygiene, literacy, budgeting and banking, shopping and cooking, transportation, safety planning, time management, and the ability to be assertive.

QUESTIONS FOR CLINICAL WORK WITH YOUTH AND PROVIDER TEAM MEETINGS

ATTACHMENT

- What is known about the quality and consistency of the youth's early child caregiver experiences?
- What quality of relationships does the youth form with peers?
- How does the youth relate to adults, program staff, and authority figures?

SELF-REGULATION

- What does it look like when the youth is experiencing unpleasant feelings (i.e. frequency, intensity, and recovery time)?
- What kinds of situations trigger unpleasant feelings?
- What methods does the youth use to calm down?

COMPETENCY

- Is the youth able to think realistically and with sound judgment about the past, present and future?
- Is the youth able to problem solve, organize/prioritize time, and plan ahead?
- What specific skills does the youth possess and what skills does the youth still need to acquire?

QUESTIONS FOR ADMINSTRATIVE REVIEW OF AGENCY POLICIES AND PROCEDURES

How do agency policies, procedures, and culture support:

- Youth's positive self-regard and ATTACHMENT to the program, peers, providers, family, and community?
- Youth's ability to learn and practice appropriate SELF-REGULATION skills?
- Youth's development of new COMPETENCIES and skills?

NEXT STEPS: After reviewing agency strengths and challenges in each area, providers and administrators can decide how to improve agency support in the three key areas. Often times, small, low or no cost efforts can make significant improvements in creating healing environments for youth.

EXAMPLES:

ATTACHMENT

- Create structured and predictable environments by establishing rituals and routines, and showing unconditional respect and acceptance.

COMPETENCY

- Create opportunities for youth to positively engage with peers, adults, and community members.

SELF-REGULATION

- Create a safe space for youth experiencing intense emotions by training providers to help youth accurately identify and manage feelings.

DEVELOPMENTAL COMPETENCIES

Psychological & Emotional Development

Empathy

Positive self-regard

Sense of autonomy

Self-regulation skills

Positive coping skills

Conflict resolution skills

Optimism coupled with realism

Ability to comfort self and others

Recognition of right and wrong

Physical Development

Healthy Habits

Personal hygiene

Nutrition and exercise

Regular medical and dental care

Risk Management

Seat belts

Condoms

Bike helmets

Social Development

Sense of belonging to society

Connectedness with parents/cargivers, peers, and other adults

Attachment to pro-social institutions such as school and church

Ability to navigate in multiple cultural contexts

Commitment to civic engagement

Intellectual Development

Essential Life Skills:

Literacy

Budgeting and banking

Shopping and cooking

Transportation and Safety planning

Essential Vocational Skills:

Job applications and interviews

Time management

Knowledge of more than one culture

Critical thinking and reasoning

Decision-making and planning

SUPPORT THE WHOLE YOUTH

RESILIENCE PYRAMIDS:

FROM BIRTH TO YOUNG ADULTHOOD

RESILIENCE BUILDING BLOCKS

COMPETENCY
Mastering
developmental
tasks of adolescence
and the ability to plan
and organize for the future

SELF-REGULATION
Developing and maintaining the
ability to identify, express, and modulate
feelings such as frustration, anger, and fear

ATTACHMENT
The capacity to form and maintain a
healthy emotional bond with another person
as a source of mutual comfort, safety, and caring (12)

RESILIENCE IN REAL LIFE

YOUTH CAN
Be insightful,
Prioritize tasks,
Plan effectively,
Make good judgments, and
Organize thoughts and actions

YOUTH DEVELOPS
Empathy,
Impulse control,
Healthy boundaries, and
Conflict management skills

YOUTH PROVIDED WITH
Receptive, attuned cargiving from and adult (12)

PROVIDER SELF-CARE STRATEGIES FOR BURNOUT AND VICARIOUS TRAUMA

PEACE: *It does not mean to be in a place where there is no noise, trouble, or hard work. It means to be in the midst of these things and still be calm in your heart.*

–Author Unknown

BUILDING RESILIENCE: ABC'S OF SELF CARE (13)

A: Awareness of one's limits, resources, and emotions.

B: Balance among personal and professional activities.

C: Connection to one's inner self, to others, and to something "larger" (e.g. spiritual).

BUILDING RESILIENCE: HOW TO'S (14)

- Make connections and build good relationships.
- Avoid seeing crises as insurmountable problems.
- Accept that change is part of living.
- Move towards goals.
- Take decisive actions.
- Look for opportunities for self-discovery.
- Nurture a positive view of yourself.
- Keep things in perspective.
- Maintain a hopeful outlook.

STRESS/BURNOUT: DECREASE OVERUSE OF "DIRECTED ATTENTION"(15)

- "Directed attention" (watching TV) leads to more burnout, whereas "locomotion in nature" (e.g., walk in the park) and "fascination" is restorative and decreases burnout.

VICARIOUS TRAUMA: MINIMIZE UNNECESSARY EXPOSURE TO TRAUMATIC MATERIAL

- Reduce viewing of traumatic media, including violent movies and news about tragic events.

CONNECTION: THE SCIENCE OF POSITIVE PSYCHOLOGY

- Health and Happiness Ratio = 3:1
- 3 positive emotions are needed for each negative emotion (16)

Sources: 1) Joyce Dorado, (2013). Self-Care for Educators: Coping with Stress in School. UCSF Healthy Environment and Response to Trauma in Schools (HEARTS), Child and Adolescent Services, Dept. of Psychiatry, University of California, San Francisco. 2) Greater Good Science Center (2013). University of California Berkeley. http://greatergood.berkeley.edu/topic/happiness/definition#how_to_cultivate

RECOGNIZING AND RESPONDING TO TRAUMA TRIGGERS

Trauma triggers are reminders of past traumatic events. Past traumatic events may include:

- Physical, sexual, or emotional abuse
- Injuries or accidents
- Interpersonal, school, or community violence
- Natural disasters, war, or terrorism

Trauma triggers may include:

- Different types of physical contact
- Different sounds, smells, or places
- Dissagreements, conflicts, or certain topics of conversation
- Unpredictable situations or sudden changes

When triggered, you may react to "there and then" past traumatic events instead of "here and now" reality. Trauma triggers may cause you to:

- Yell or fight
- Get nervous, angry, or frustrated
- Shut down, get quiet, and want to be alone
- Drink, smoke, or eat to feel better

TIPS FOR RECOGNIZING TRAUMA TRIGGERS:

1. Notice your current mood, state of mind, and environment
2. Notice certain situations and places that remind you of past traumatic events
3. Notice when, where, and how you react to reminders of past traumatic events

TIPS FOR RESPONDING TO TRAUMA TRIGGERS:

Get Emotional: Talk to a trusted friend or caring adult about traumatic events, triggers, and reactions

Get Mindful: Stop what you are doing, pay attention to what's happening in your body, and breathe deeply

Get Physcial: Move your body- stretch, walk, run, or dance on a regular basis

Get Creative: Try writing in a journal, drawing, painting, freestyling, or singing

Get Spiritual: Meditate, go out in nature, or go to a religious place of worship

Get Community: Volunteer/participate in community projects such as murals, gardens, or mentoring

EXAMPLE: You smell cologne that reminds you of a time when you were raped. You are immediately triggered. You feel scared and begin to feel anxious.

RESPONSE 1: (You do NOT recognize your triggers). You decide to shake it off, call your friends, and get some drinks or go smoke to suppress your feelings. You hope the trigger never happens again. When you get home, you are left alone to deal with your fears and anxieties.

RESPONSE 2: (You do recognize your triggers). You are aware of your fears and anxieties and understand you have been triggered. You have already decided that when you are triggered you will stop, breathe deeply, and call your cousin to briefly talk about what happened. After expressing your emotions, you feel like it is an issue of the past and are able to continue with your day.

MINDFULNESS SKILLS

MINDFULNESS IS:

- Paying attention, here and now, with kindness and curiosity. (16)
- A mental state, characterized by focused awareness of one's thoughts, actions or motivations.
- A component of many therapeutic treatments for trauma.

BUILDING MINDFULNESS SKILLS CAN HELP YOUTH AND ADULTS:

1. Become more aware of negative judgments and thoughts.
2. Build more positive decision-making skills.
3. Become more focused on the moment.
4. Be less reactive to their environments.
5. Be utilized in group meetings or individual sessions with youth, or among adult providers.

MINDFULNESS "WHAT" SKILLS

Observe

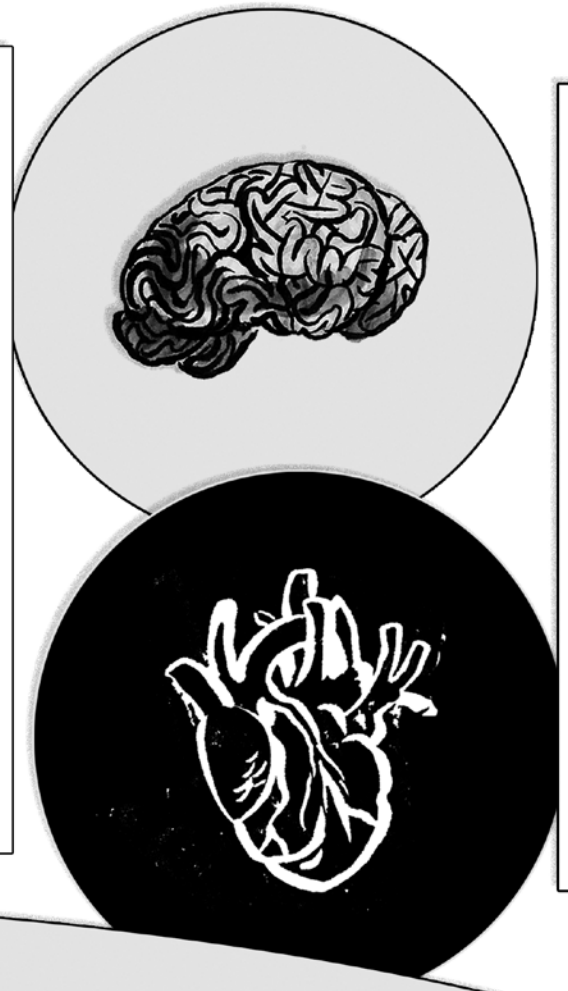
- Just notice: Use your 5 senses- sight, sound, taste, touch, smell
- Watch your thoughts and feelings come and go: Don't push them away or hold onto them

Describe

- Put words on the experience: "my stomach muscles are tightening"
- Name your feelings: "I'm so mad I could scream"
- Label your thoughts as thoughts, not facts: "Thinking you're dumb doesn't mean that you are dumb"
- Name thoughts, feelings, and sensations separately

Participate

- Become one with your experience
- Dive into what you do and get really into it without being self-conscious or fearful
- Practice, practice, practice, like learning how to ride a bike



MINDFULNESS "HOW" SKILLS

Don't judge

- See without evaluating
- Acknowledge without judgment
- Don't judge your judging

Stay focused

- Do ONE thing at a time
- Let go of distractions
- Dive into the current moment, the here and now
- Concentrate your mind

Do what works

- Focus on what's going to help
- Do what you need to do to achieve your goals
- Play by the rules
- Act as skillfully as you can
- Let go of feelings that hurt you and others

Source: SPARCS: Structured Psychotherapy for Adolescents Responding to Chronic Stress- Group Trauma Treatment Curriculum (V16).(16-18)

SLOW DOWN, ORIENT, AND SELF-CHECK (SOS): A TOOL FOR YOUTH/YOUNG ADULTS (19)

What is the situation? What is going on? _____

Practice steps 1, 2, & 3. Circle ratings for step 3.

STEP 1: SLOW DOWN

- Pause, take a time out, calm your body, relax.
- Take a deep breath- feel the air, listen to the sounds around you, notice your heartbeat.
- One thought at a time.

STEP 2: ORIENT YOURSELF

- Bring your mind and body back to the present time and place.
- Look around and notice where you are, who you're with, and what you're doing.
- Feel yourself (feet on the ground, sitting in a chair).

STEP 3: SELF CHECK

PERSONAL DISTRESS

Right Now I Feel...

Completely Calm	1	2	3	4	5	6	7	8	9	10	Most Distressed Ever

PERSONAL CONTROL

Right Now I Feel...

Completely in Control	1	2	3	4	5	6	7	8	9	10	Totally Out of Control

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CARE

SPECTRUM OF TRAUMA-INFORMED CARE: TERMINOLOGY

TRAUMA-SPECIFIC INTERVENTIONS (1)

- Practices developed to address trauma experienced by individuals, families, and communities.
- Shown to work with specific age groups, settings, and types of trauma.
- Most often used by practitioners trained in the specific intervention.

TRAUMA-SPECIFIC SERVICES (2)

- Programs that address trauma with a continuum of interventions from screening to treatment to recovery supports.
- Recognize that recovery occurs within a context of relationships.
- Characterized by belief in persuasion and trust rather than coercion, ideas rather than force, and mutuality rather than control.

TRAUMA-INFORMED CARE/APPROACHES (3)

- A program, organization, or system that realizes the widespread impact of trauma and understands potential paths for healing.
- Recognizes signs and symptoms of trauma in providers, clients, and others involved with the system.
- Responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings.
- **Trauma-informed approaches ask: "What happened to you?" NOT "What's wrong with you?"**

THREE R'S OF TRAUMA-INFORMED APPROACHES TO CARE

WHAT IS A TRAUMA-INFORMED APPROACH? (2,3)

- How a program, agency, organization or community thinks about and responds to those who have experienced or may be at risk for experiencing trauma- includes a change in organizational culture.
- All components of the organization incorporate a deep understanding of the prevalence and impact of trauma, the role that trauma plays, and the complex and varied paths in which people recover and heal.
- Designed to avoid re-traumatizing those who seek assistance, to focus on safety first, commitment to do no harm, and facilitates participation and meaningful involvement of consumers, families, and trauma survivors in the planning of services and programs.
- Requires closely knit collaborative relationships with other public sector service systems.

THREE KEY ELEMENTS

1. *Realizing* the prevalence of trauma.
2. *Recognizing* how trauma affects all individuals involved with programs, organizations, or systems, including the workforce.
3. *Responding* by putting knowledge into practice.

REALIZING

- All people at all levels of an organization or system have a basic realization about trauma and understand how trauma affects individuals, groups, organizations, and communities.
- There is an understanding that trauma plays a role in mental and substance use disorders and should be systematically addressed in treatment and recovery settings.
- There is a realization that trauma is not confined to the behavioral health service sector- trauma is integral to all other systems including child welfare, criminal justice, primary health care, and education, and is often a barrier to effective outcomes across systems of care.

RECOGNIZING

- People in the organization or system are able to recognize the signs of trauma.
- Signs may be gender, age, or setting-specific and may be experienced by those seeking service and those providing services.
- The organization assumes that everyone is at risk of experiencing a traumatic event at some point in life and might benefit from a trauma-informed approach, including trauma screening and assessment.

RESPONDING

- Programs, organizations, or systems respond by applying the principles of a trauma -informed approach to all areas of functioning.
- People in every part of the organization, from the front desk to the executive, have changed their language, behaviors and policies to take into consideration the experiences of trauma among children and adult users of services and among service providers.
- Organizations have a meaningful definition of trauma; have a culture based on beliefs about resilience, recovery and healing; and accept key values and principles that guide the way the organization is designed, operated, and provides services to meet the unique needs of those impacted by trauma.

Source: National Association of State Mental Health Program Directors (2012, September). Changing Communities, Changing Lives. Report prepared for the Substance Abuse and Mental Health Services Administration's National Center for Trauma-Informed Care. Alexandria, VA: (Joan Gillece, Project Director; Andrea Blanch, Author).

KEY PRINCIPLES OF TRAUMA-INFORMED APPROACHES TO CARE

A trauma-informed approach reflects the adoption of underlying values or principles rather than a specific set of procedures. These values or principles are generalizable across all settings, although language and application may be setting or sector-specific.

1. ***SAFETY:*** Throughout the organization, providers and people served feel physically and psychologically safe; including physical settings and interpersonal interactions.

2. ***TRUSTWORTHINESS AND TRANSPARENCY:*** Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among providers, clients, and family members of those served.

3. ***COLLABORATION AND MUTUALITY:*** There is true partnering and leveling of power differences between providers and clients and among organizational staff from direct care to administrators; there is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.

4. ***EMPOWERMENT:*** Throughout the organization and among clients served, individuals' strengths are recognized and validated and new skills are developed as necessary.

5. ***VOICE AND CHOICE:*** The organization aims to strengthen client and family members' experience of choice, and recognizes that every person's experience is unique and requires an individualized approach.

6. ***PEER SUPPORT AND MUTUAL SELF-HELP:*** Are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.

7. ***RESILIENCE AND STRENGTHS BASED:*** A belief in resilience and the ability of individuals, organizations, and communities to heal and promote recovery from trauma; builds on what clients, providers, and communities have to offer rather than responding to their perceived deficits.

8. ***INCLUSIVENESS AND SHARED PURPOSE:*** The organization recognizes that everyone has a role to play in a trauma-informed approach; one does not have to be a therapist to be therapeutic.

9. ***CULTURAL, HISTORICAL, AND GENDER ISSUES:*** Are addressed; the organization actively moves past cultural stereotypes and biases, offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.

10. ***CHANGE PROCESS:*** Is conscious, intentional and ongoing; the organization strives to become a learning community, constantly responding to new knowledge and developments.

Source: Substance Abuse and Mental Health Services Administration (SAMHSA). 2012. Trauma Definition Working Draft. http://www.samhsa.gov/traumajustice/traumadefinition/index.aspx

GUIDELINES FOR IMPLEMENTATION OF TRAUMA-INFORMED APPROACHES TO CARE

Guidelines can provide a roadmap to help individuals and agencies get started in the process of implementing a trauma-informed approach. In a trauma-informed approach, change permeates all levels of an organization or system, and all aspects of organizational culture are in alignment. While different organizations have varying responsibilities and influence, the following organizational domains are identified as potentially relevant across a variety of settings.

1. ***GOVERNANCE AND LEADERSHIP:*** Leadership and governance bodies support and invest in implementing and sustaining a trauma-informed approach. There is an identified point of responsibility within the organization to lead and oversee this work.

2. ***POLICY:*** There is a written policy establishing a trauma-informed approach as an important part of the organizational mission.

3. ***INVOLVEMENT OF TRAUMA SURVIVORS, CONSUMERS, AND FAMILY MEMBERS:*** These groups have significant involvement, voice, and meaningful choice at all levels and in all areas of organizational functioning, (e.g., program design, implementation, service delivery, quality assurance, access to peer support, workforce development, and evaluation).

4. ***CROSS SECTOR COLLABORATION:*** There is collaboration between adult and children/youth services, prevention and treatment, health and human service sectors, education, legal, child welfare, and criminal justice sectors and systems.

5. ***ORGANIZATIONAL PROTOCOLS:*** Organizational procedures reflect trauma-informed principles, including collaborations with other agencies.

6. ***INTERVENTIONS:*** All interventions, including screening and assessment, are based on the best available empirical evidence, are culturally appropriate, and reflect principles of a trauma-informed approach. A trusted and effective referral system is in place, and trauma-specific interventions are acceptable, effective, and available for individuals, youth, and families seeking services.

7. ***TRAINING AND WORKFORCE DEVELOPMENT:*** Training on trauma and how to respond is available for all staff. A human resource system incorporates trauma-informed principles in hiring, supervision, and staff evaluation. Procedures are in place to support staff with trauma histories.

8. ***CONSULTATION AND SUPERVISION:*** All levels of staff receive regular and ongoing consultation and supervision around issues of trauma, vicarious trauma, and burnout faced in the work place, including interactions between staff and clients, and among staff themselves.

9. ***PHYSICAL ENVIRONMENT:*** Investments are made to ensure the physical environment promotes a sense of safety for clients and staff.

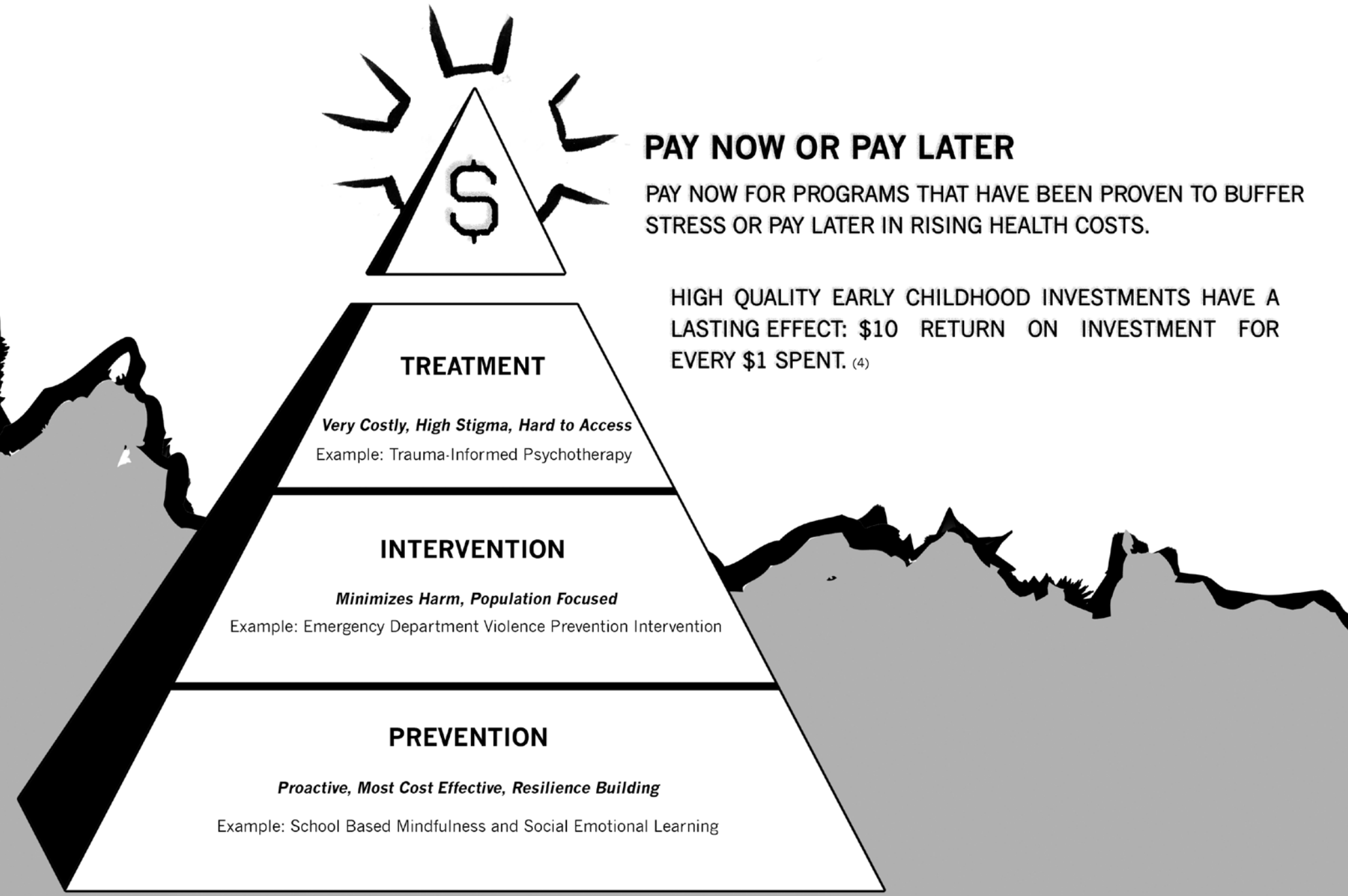
10. ***QUALITY ASSURANCE:*** There is ongoing assessment, tracking, and monitoring of trauma-informed principles.

11. ***FINANCING:*** Financial structures are designed to support a trauma-informed approach including initial staff training, ongoing consultation, supervision, and support for all staff, appropriate facilities, and evidence based trauma-specific services.

12. ***EVALUATION:*** Measures used to evaluate service or program effectiveness reflect an understanding of trauma.

Source: Substance Abuse and Mental Health Services Administration (SAMHSA). 2012. Trauma Definition Working Draft. http://www.samhsa.gov/traumajustice/traumadefinition/index.aspx

TRAUMA-INFORMED PREVENTION, INTERVENTION, AND TREATMENT PYRAMID



PAY NOW OR PAY LATER

PAY NOW FOR PROGRAMS THAT HAVE BEEN PROVEN TO BUFFER STRESS OR PAY LATER IN RISING HEALTH COSTS.

HIGH QUALITY EARLY CHILDHOOD INVESTMENTS HAVE A LASTING EFFECT: $10 RETURN ON INVESTMENT FOR EVERY $1 SPENT. (4)

CULTURALLY SENSITIVE APPROACHES TO TRAUMA

APPROACHES THAT ARE NOT TRAUMA-INFORMED ASK: "WHAT'S WRONG WITH YOU."	TRAUMA-INFORMED APPROACHES ASK: "WHAT HAPPENED TO YOU."
WHAT "HELP" LOOKS LIKE (NOT TRAUMA-INFORMED)	**WHAT "HELP" LOOKS LIKE (TRAUMA-INFORMED)**
• The "helper" decides what "help" looks like.	→ • A sense of trust and safety is mutually defined, created, and sustained in all relationships.
• Focused on "needs" as defined by helper.	→ • Collaboration and shared decision-making exists.
• Relationships are based solely on problem-solving and resource coordination, not creating meaningful connections.	→ • Crisis becomes opportunity for growth and connection.
• Safety is defined only as risk management.	→ • Authentic relationships are emphasized in a context of wellness.
• Common experience is assumed and defined by setting: i.e. in clinical setting experience is based only on "illness" and coping with "illness."	→ • It is recognized that people rarely have the same experience or make the same meaning out of similar events.

COMMON CULTURAL MISTAKES ABOUT TRAUMA	MORE CULTURALLY SENSITIVE APPROACHES TO TRAUMA (5)
• Assuming everyone who has experienced violence needs professional help.	→ • Assuming people are resilient and giving them many opportunities to tell you if they need help.
• Focusing on the most extreme instances of violence as the most damaging.	→ • Allowing individuals to define what aspects of their experiences have been most traumatic and recognizing that this may change over time.
• Assuming that violence is unusual, an aberration, and generally perpetrated by individuals.	→ • Recognizing that violence is perpetrated by groups and institutions, not only individuals, and may be so common that people become desensitized to it.
• Relying only on DSM diagnoses or lists of trauma "symptoms."	→ • Recognizing that political and social oppression may affect priorities and values; allowing individuals to define the meaning of their experiences.
• Applying norms and standards of behavior without considering political and social context.	→ • Recognizing that trauma responses are varied and that different cultures express grief and loss and understand trauma differently; learning how different people and cultures expresses distress.
• Assuming that one person's story represents the "typical" story for a group of people.	→ • Recognizing that one person's story is just one person's story.
• Inadvertently highlighting the stories of people that fit cultural stereotypes.	→ • Providing opportunities for many people to share their stories, noticing what is unique, and making sure many points of view are represented.
• Assuming that if people speak English, you don't have to worry about an interpreter or translated documents.	→ • Recognizing that some topics are very difficult to talk about in anything other than your first language; knowing and acting within the law about provision of language assistance services.
• Assuming that people always (or never) want to tell their stories and that if people want help they will ask for it.	→ • Being aware that self-disclosure and help-seeking vary widely across cultures and may be dependent upon whether an individual feels safe; learning different cultural norms and expectations.

Source: Engaging Women in Trauma-Informed Peer Support: A Guidebook. Blanch, A., Filson, B., and Penny, D., 2012. http://www.nasmhpd.org/publications/engagingWomen.aspx

RESTORATIVE PRACTICES FOR TRAUMA-INFORMED CARE

RESTORATIVE PRACTICES

Foundation: People are happier, more cooperative and productive, and more likely to make positive changes when those in positions of authority do things with them, rather than to them or for them.
Includes: "Restorative justice" (criminal justice), "empowerment" (social work), "trauma-informed consequences," (behavioral health), "positive discipline" (education), and "horizontal management" (organizational leadership).
Examples: In schools, the use of restorative practices has demonstrated reliable reduction of misbehavior, bullying, violence and crime among students and improvements in overall learning climates.(6)In juvenile justice, the use of restorative practices has demonstrated significant reductions in offending rates and improvements in youth attitudes.(6)

PUNISHMENT VS. CONSEQUENCES

Punishment: Used by specific authorities to enforce obedience. Usually used to assert power and control and often leaves youth feeling helpless, powerless, and shamed.
Consequences: Intentionally designed to teach, change, or shape behavior. Logical consequences are clearly connected to behavior, given with empathy and a respectful tone, and are reasonable to the behavior.

CONSISTENCY AND INDIVIDUALIZED RESPONSES

Consistency: Rules and consequences apply to everyone, understanding that predictability and routines can help a youth feel safe.
Individualized Responses: Consequences are consistent with youth's needs and level of functioning, while also holding youth accountable for their actions. Some youth are more highly impacted by past traumatic experiences and may need tailored consequences.

ADOLESCENT DEVELOPMENT AND TRAUMA-INFORMED CONSEQUENCES

- The adolescent brain is acutely sensitive to positive reward and relatively insensitive to negative consequences.(7)
- Disrupting service delivery or learning (i.e. exiting youth from a program/site or restricting participation) may lead to more negative outcomes than positive.
- Some youth will repeatedly test limits and challenge providers with their behaviors until they build trust and feel connected.
- If providers have to ask youth to leave or restrict access due to safety concerns, maintaining contact with the youth can "open the door" to important learning opportunities and engagement.

CHARACTERISTICS OF TRAUMA INFORMED CONSEQUENCES

- Take into account trauma triggers and past traumatic experiences.
- Attempt to retain youth in services/learning, in spite of problematic behavior.
- Consider the function of problematic behavior and help youth develop more effective strategies for getting needs met.
- Shape youth's behavior by assisting them to recognize the impact of their actions on themselves and their community.
- Build youth's capacity to manage strong emotions and increase confidence in what they are able to accomplish.
- Invest great energy, creativity, and resources upfront in order to support long-term success in helping youth succeed.
- Take the long view and understand that behavior change is slow and incremental.

CHALLENGES OF IMPLEMENTING TRAUMA-INFORMED CONSEQUENCES

- May require a paradigm shift in the way providers understand and respond to challenging, negative, and disruptive behavior.
- Providers must balance what is best for individual youth with needs of other youth and the agency as a whole.
- Best implemented in a calm and thoughtful manner, with time for planning and processing between youth and providers, and among providers and administrators.
- Provider safety and wellness must be attended to in order for providers to feel well equipped to be attuned and responsive to youth.
- Providers must receive adequate supervision and ongoing support for learning and implementing trauma-informed consequences.

Sources: 1) Wachtel, T. (2012). Defining Restorative. International Institute for Restorative Practices. www.iirp.edu. 2) Schneir, A., Ballin, D., Carmichael, H., Stefanidis, N., Phillips, L., Hendrickson, C., and de Gyarfas, L. 2009. The Community Trauma Treatment Center for Runaway and Homeless Youth. An Initiative of the Hollywood Homeless Youth Partnership. SAMHSA Grant # SM57247. http://hhyp.org/download-material-2/

TRAUMA-INFORMED CONSEQUENCES IN PRACTICE (PAGE 1 OF 3)

Well-intentioned providers assisting youth with trauma histories and behavioral challenges may unknowingly mirror aspects of traumatic relationships:

Characteristics of Traumatic Relationships

- Betrayal occurs at the hands of a trusted caregiver or supporter.
- Hierarchical boundaries are violated and then re-imposed at the whim of the abuser.
- Secret knowledge, secret information, and secret relationships are encouraged and maintained.
- The voice of the victim is unheard, denied, or invalidated.
- The victim feels powerless to alter or leave the relationship.
- Reality is reconstructed to represent the values and beliefs of the abuser.
- Events are reinterpreted and renamed to protect the guilty.

How Helping Relationships Can Re-traumatize Youth

- Youth feel betrayed by the organization, program, or provider.
- Youth-provider relationships are inconsistent, unclear, or confusing.
- Provider-agency relationships allow for and maintain secrets.
- Youth feel there is no opportunity to be heard, and their perspectives are not taken into account.
- Youth feel powerless to alter or leave the relationship or agency.
- Reality is reconstructed to match the needs and values of the provider or agency, not the youth.

As providers respond to challenging behaviors with trauma-informed consequences, it may be useful to explore the following questions and answers:

1. What is the purpose of enforcing rules? Is it to discipline/teach youth how to manage emotions, or to enforce the rules for the "rule's sake?"
2. Is a youth intentionally pushing my buttons? Why would the youth want this type of attention from me? Does the youth prefer negative attention to no attention at all?
3. How much of my response is because I feel personally hurt, offended, disrespected, helpless and frightened, or need to prove that I am in control?
4. What assumptions am I making about this youth's behavior? Could there be another explanation?
5. What options do I have to respond to this behavior? How does the youth expect me to respond?
6. Which option most closely fits my intent to maintain safety while building the youth's capacity to manage intense emotions and learn more effective behavior? Which option is least disruptive to service/learning delivery?

Why does it seem like some youth are asking to be discharged from services by repeatedly breaking the rules even when they know the consequences?

Many youth bring multiple experiences of rejection and abandonment by family and other caregivers. Due to past experiences, there is an expectation that providers will also reject them and, in turn, abandon them. In order to protect themselves, consciously or not, many youth act out to speed up the rejection that they are convinced is coming anyway.

If we don't exit/punish youth when they break the rules, aren't we enabling them?
No. When a youth that is highly impacted by past trauma is exited, what is the lesson? Although providers may believe youth are learning they can't write on walls or disrespect providers, mostly providers are just confirming a youth's belief that they are unlovable and undeserving of attention and support. It is not suggested that agencies and providers ignore inappropriate behavior. Instead, it is recommended that providers work with youth to identify problematic behavior, put it in the context of trauma, and help youth find different ways to express anger, frustration, or sadness. The goal is for youth to know that providers can see far beyond the problem behavior, and see the youth's capabilities and potential to succeed.

Source: Stefanidis, N., Schneir, A., Ballin, D., Carmichael, H., Gore, P., de Gyarfas, L., Hendrickson, C., Hubbard, E., McGaffey, J., Phillips, L., Rodriguez, M., and Schwartz, J. (2010). Trauma-Informed Consequences for Homeless Youth. The Community Trauma Treatment Center for Runaway and Homeless Youth. SAMHSA Grant #SM57247. ©Hollywood Homeless Youth Partnership. http://hhyp.org/download-material-2/

TRAUMA-INFORMED CONSEQUENCES IN PRACTICE (PAGE 2 OF 3)

INCIDENT # 1: Youth is verbally aggressive towards a provider.

Punishment

Provider Interpretation: Youth is being disrespectful. Youth doesn't appreciate the services/learning offered. A firm example needs to be set condoning this type of verbal abuse.

Reaction: Provider threatens to exit youth if behavior continues.

Trauma-Informed Consequences

Provider Reflection and Interpretation: What is going on in the environment that is setting the youth off? Youth needs to know it's inappropriate to verbally abuse providers and at the same time get help to develop more constructive self-regulation skills.

Response: Youth is asked to cool off in a safe place. Provider processes the experience with the youth when appropriate (i.e. after the youth is no longer visibly agitated). Provider shares with youth their observation regarding the interaction and asks for feedback. Provider and youth explore alternative/pro-social ways of communicating feelings.

INCIDENT # 2: Youth comes to agency/site but doesn't do anything, just sits and dozes.

Punishment

Provider Interpretation: The youth is lazy, is taking advantage of services/learning, and should be doing something productive. Providers help youth, not just let them sit around and do nothing.

Reaction: Providers don't invest time in the youth.

Trauma-Informed Consequences

Provider Reflection and Interpretation: The youth is very tired. Services/learning were made available to the youth. What could be interfering with the youth's ability to participate/focus? Lots of youth are worried about failing so they don't even want to try. How can the youth be engaged?

Response: Provider approaches the youth and asks if anything is needed. Provider tries to engage youth in pro-social activity (i.e. game, group) to try and engage further. Even if the youth is generally unresponsive, the provider gently continues to try and engage periodically and spends as much time with the youth as tolerated by the youth.

INCIDENT # 3: Youth has a crush on a provider and follows them around.

Punishment

Provider Interpretation: This is very awkward. I don't want to hurt the youth's feelings but I don't want to give them the wrong idea. It is probably better if the youth works with someone else.

Reaction: Youth is given a new provider.

Trauma-Informed Consequences

Provider Reflection and Interpretation: This young person is trying to connect with me. I might be one of few people who sincerely tried to help this youth. This is very awkward but with some supervision and support, I think I can help.

Response: Provider gets supervision and support in talking to the youth about the crush and working to reinforce appropriate boundaries and expectations.

Source: Stefanidis, N., Schneir, A., Ballin, D., Carmichael, H., Gore, P., de Gyarfas, L., Hendrickson, C., Hubbard, E., McGaffey, J., Phillips, L., Rodriguez, M., and Schwartz, J. (2010). Trauma-Informed Consequences for Homeless Youth. The Community Trauma Treatment Center for Runaway and Homeless Youth. SAMHSA Grant #SM57247. ©Hollywood Homeless Youth Partnership. http://hhyp.org/download-material-2/

TRAUMA-INFORMED CONSEQUENCES IN PRACTICE (PAGE 3 OF 3)

INCIDENT # 4: Youth acts out and storms out of a group/class.

Punishment

Staff Interpretation: This young person is disrespecting the group and disrespecting me. I can't create a cohesive group when the youth feels free to leave at will. It's not fair to the other youth participants/learners.

Reaction: Youth receives a warning to be exited from the group/class if it happens again.

Trauma-Informed Consequences

Provider Reflection and Interpretation: Did something in the group/class trigger the youth or bring up uncomfortable feelings or memories? What else could I do to help the youth feel safe?

Response: Provider checks in to find out if the youth is ready to rejoin the group/class. If not, the provider talks to the youth after the group/class to find out what happened. The provider lets the youth know where they can go during a group/class, when feeling upset or anxious, to sit quietly or talk with a trusted adult (i.e. safe space- counselor, wellness center, etc). The provider invites the youth to rejoin the group/class when ready.

INCIDENT # 5: Youth enters agency/site clearly drunk or high.

Punishment

Provider Interpretation: The youth knows they are not allowed to come to the agency/site under the influence. This is totally disruptive to other youth and providers. Youth needs to learn that this is just not allowed.

Reaction: Youth is exited and referred to detox/rehab.

Trauma-Informed Consequences

Provider Reflection and Interpretation: This is disruptive to other youth and providers. However, if I send the youth back outside, they will be vulnerable to being victimized or offending. We need to find a safe place for the youth to sober up. Youth needs further assessment regarding substance use.

Response: Youth is asked to move to secure place within agency/site to sober up and be safe. When youth is more coherent, a provider discusses the circumstances of youth's drug/alcohol use. The youth is reminded about the provider's concern for the youth's safety and the agency/site policies about using. The youth is encouraged to speak to a substance abuse counselor.

Source: Stefanidis, N., Schneir, A., Ballin, D., Carmichael, H., Gore, P., de Gyarfas, L., Hendrickson, C., Hubbard, E., McGaffey, J., Phillips, L., Rodriguez, M., and Schwartz, J. (2010). Trauma-Informed Consequences for Homeless Youth. The Community Trauma Treatment Center for Runaway and Homeless Youth. SAMHSA Grant #SM57247. ©Hollywood Homeless Youth Partnership. http://hhyp.org/download-material-2/

TRANSFORMING TRAUMA THROUGH SOCIAL ACTION

SOCIAL ACTION: A TOOL FOR HEALING FROM TRAUMA

- Trauma often leaves survivors feeling voiceless, hopeless, and powerless.
- Taking social action, individually or as part of a group, can be a positive act of healing for trauma survivors, especially those in positions of lesser cultural power, including youth, women, and people of color, and can help to reclaim power in the world.
- Social action includes working to change harmful policies and practices and overcome injustice.
- Social action requires many different skills, which provides opportunities for all group members to utilize their strengths and make significant contributions.
- The process of healing from trauma often includes: 1) An increased sense of awareness and rage about the traumatic events experienced; and 2) Outrage at the sight of others harmed or treated unjustly.
- If anger and rage is left unexamined and unchecked, it can be hurtful to the self and others.
- If anger and rage is recognized and transformed to help the self and others, it can be a powerful force for positive healing and social change.

A GOOD PLACE TO START

In order to break down a social issue and create a strong position on which to enact change, individuals and groups can start by answering the following questions:

- What is it we want to change?
- What outcomes or solutions will satisfy us?
- What are we willing/not willing to trade, compromise, or let go of?
- What information already exists on the issue and what struggles are currently being fought for the issue?
- Is a rule, policy, or law being violated?
- What additional information/resources are needed and how will the group get them?
- Who has the power to change the situation/fix the problem, and how can the group engage them in the struggle?
- What are possible barriers and solutions to reaching an outcome that facilitates healing and social change for those involved?
- When there is conflict, is there a point of shared interest on which there is some agreement?

NEXT STEPS

- Develop a clear and concise understanding of the problem and desired solution to the problem in about five spoken sentences and no more than one written page; this is the position statement.
- When presenting the position statement, focus on facts not feelings for greatest impact on the decision-maker.
- Decide who to approach and how to approach them.
- Try starting with the lowest pressure technique and apply only as much as necessary to succeed.
- The activities below are arranged in order of increasing pressure, from lowest to highest:
    - o Meet with management or policy makers.
    - o Meet with the responsible government officials.
    - o Develop letter-writing, fax, phone, e-mail, and social network campaigns.
    - o Develop and distribute position papers and fact sheets throughout the community.
    - o Join relevant committees and task forces.
    - o Testify at public hearings.
    - o Launch media campaigns.
    - o Organize rallies and demonstrations.
    - o File lawsuits.

ADDITIONAL RECOMMENDED ACTIVITIES

- Create healing circles and opportunities to connect and bond in peer groups and across multiple generations.
- Organize candle light vigils to honor those lost/injured and to mourn as a community.
- Design public murals and artwork that represents community strength and power.

Source: Engaging Women in Trauma-Informed Peer Support: A Guidebook. Blanch, A., Filson, B., and Penny, D. (2012). http://www.nasmhpd.org/publications/engagingWomen.aspx

MANY MEDICINES:

TRUAMA-INFORMED EVIDENCE-BASED BEST PRACTICES AND PROMISING APPROACHES (PAGE 1 OF 6)

For extended and updated listings of programs nationwide, please visit:
National Child Traumatic Stress Network (NCTSN): http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices
Substance Abuse Mental Health Services Administration (SAMHSA): http://www.nrepp.samhsa.gov/

EMERGENCY DEPARTMENT VIOLENCE PREVENTION INTERVENTION

Designed to: Reduce injury recidivism and criminal recidivism by working directly with survivors of violent injury and connecting at teachable moments in the hospital setting.

Components:

- May include intensive case management, crisis response, mental health services for youth/young adults and families, along with access to after school, vocational, life skills, and tattoo removal programs.

Resources:

1. National Network of Hospital Based Violence Intervention Programs
   www.nnhvip.org
2. Youth Alive
   www.youthalive.org/caught-in-the-crossfire
3. Wrap-Around Project
   www.violenceprevention.surgery.ucsf.edu

EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

Designed to: 1) Overwrite original memory of the trauma with more adaptive beliefs, emotions, and somatic responses, and 2) Reduce trauma-related stress, anxiety, and depression symptoms.

Components:

- 1-3 or more 60-90 minute sessions depending on complexity of trauma.
- Target trauma triggers and related psychological distress are reviewed and processed with a focus on accessing positive images and beliefs.
- Repetitive 30-second dual-attention exercises, typically side-to-side eye movements guided by therapist's finger, are repeated until client reports no distress.

Resources:

EMDR Training Institute: http://www.emdr.com/index.php

PHARMACOTHERAPY

Designed to: Reduce specific post traumatic stress related symptoms including nightmares, difficulty sleeping, and anxiety.

Components:

- Medication treatment to be taken as prescribed by doctor.

Resources:

National Child Traumatic Stress Network
http://www.nctsnet.org/sites/default/files/assets/pdfs/effective_treatments_youth_trauma.pdf

TRAUMA FOCUSED COGNITIVE BEHAVIORAL THERAPY (TF-CBT)

Designed to: Reduce levels of post traumatic stress symptoms including anxiety, depression, and dissociation.

Components:

- 60-90 minute sessions once a week for 12-16 weeks, based on PRACTICE skills.
- P: Psycho-education about childhood trauma and PTSD for youth and parent/caregiver.
- P: Parenting management skills for parent/caregiver.
- R: Relaxation skills individualized to youth and parent/caregiver.
- A: Affective modulation skills adapted to the youth, family and culture.
- C: Cognitive coping: connecting thoughts, feelings, and behaviors related to trauma.
- T: Trauma narrative: assisting youth in sharing verbal, written, or artistic narrative about the trauma and related experiences, and cognitive and affective processing of the trauma experiences.
- I: In vivo exposure and mastery of trauma reminders if appropriate.
- C: Conjoint parent-youth sessions to practice skills and enhance trauma-related discussions.
- E: Enhancing future personal safety and enhancing optimal developmental trajectory through providing safety and social skills training as needed.

Resources:

Web Based Learning Course for TF-CBT
http://tfcbt.musc.edu

MANY MEDICINES:

TRUAMA-INFORMED EVIDENCE-BASED BEST PRACTICES AND PROMISING APPROACHES (PAGE 2 OF 6)

ATTACHMENT, SELF-REGULATION, AND COMPETENCY (ARC)

Designed to: : 1) Reduce posttraumatic stress symptoms, anxiety, and depression, 2) Increase adaptive and social skills among youth, and 3) Reduce distress among parents/caregivers, and 3) Parents/caregivers view their children's behaviors as less dysfunctional.

Components:

- Flexible framework, rather than a protocolized intervention for working with youth and families who have experienced multiple and/or prolonged traumatic stress.
- Identifies three core domains frequently impacted among traumatized youth, and relevant to future resiliency: attachment, self-regulation, and competency.
- Identifies ten building blocks of trauma-informed treatment and services within the core domains.
- Attachment: 1) caregiver affect management, 2) attunement, 3) consistent response, 4) routines and rituals.
- Self regulation: 5) affect identification, 6) affect modulation, 7) affect expression.
- Competency: 8) developmental tasks, 9) executive functioning, 10) self development.

Resources:

Trauma Center at Justice Resource Institute
http://www.traumacenter.org/research/ascot.php

STRUCTURED PSYCHOTHERAPY FOR ADOLESCENTS RESPONDING TO CHRONIC STRESS (SPARCS)

Designed to: Address the needs of chronically traumatized adolescents who may still be living with ongoing stress and experiencing problems in several areas of functioning.

Components:

- 16-session group intervention.
- Areas include: difficulties with affect regulation and impulsivity, self-perception, relationships, somatization, dissociation, numbing and avoidance, struggles with purpose, meaning, and worldviews.
- Group members learn and practice each of the core SPARCS skills including: mindfulness practice, relationship building/communication skills, distress tolerance, problem-solving, and meaning making.
- Treatment also includes psychoeducation regarding stress, trauma, and triggers.

Resources:

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
http://sparcstraining.com/

INTEGRATIVE TREATMENT OF COMPLEX TRAUMA

Designed to: 1) Decrease depression, anxiety, anger, posttraumatic stress, dissociation, internalizing symptoms, externalizing symptoms, and sexual concerns, 2) Increase affect regulation capacities, enhanced self-esteem, and a greater sense of self-efficacy.

Components:

- 16-36 sessions.
- Interventions are adapted to youth's specific symptoms, culture, and age, and include relationship-building, psychoeducation, affect regulation training, trigger identification, cognitive processing, titrated emotional processing, mindfulness training, collateral treatments with parents and families, group therapy, and system-level advocacy.
- Specific approaches for complex trauma treatment include aspects of the Self Trauma model (Briere, 2002; Briere & Scott, 2006), Trauma Focused Cognitive Behavioral Therapy (Cohen et al., 2004), and traumatic grief therapy (Saltzman et al., 2003).

Resources:

Integrative Treatment of Complex Trauma for Adolescents (ITCT-A): A Guide for the Treatment of Multiply-Traumatized Youth
www.johnbriere.com

TRAUMA AFFECT REGULATION: GUIDE FOR EDUCATION AND THERAPY (TARGET)

Designed to: Prevent and reduce PTSD symptoms, including rage, traumatic grief, survivor guilt, shame, interpersonal rejection, and existential/spiritual alienation.

Components:

- 10 sessions, based on FREEDOM skills.
- F: Self-regulation via Focusing (SOS: Slow down, Orient, Self-Check)
- R: Processing current traumatic stress reactions via Recognizing current triggers
- EE: Emotions, and cognitive Evaluations
- D: Strength-based reintegration by Defining core goals
- O: Identifying currently effective responses (Options)
- M: Affirming core values by Making positive contributions

Resources:

Trauma Affect Regulation: Guide for Education and Therapy
http://www.ptsdfreedom.org/index.html
Advanced Trauma Solutions
http://www.advancedtrauma.com/index.html

MANY MEDICINES:

TRUAMA-INFORMED EVIDENCE-BASED BEST PRACTICES AND PROMISING APPROACHES (PAGE 3 OF 6)

SEEKING SAFETY

Designed to: Reduce substance abuse and post traumatic stress symptoms.

Components:

- Safety: Helping clients attain safety in their relationships, thinking, behavior, and emotions.
- Integrated treatment: Working on both PTSD and substance abuse at the same time.
- A focus on ideals to counteract the loss of ideals in both PTSD and substance abuse.
- Four content areas: cognitive, behavioral, interpersonal, case management.
- Attention to clinician processes: Helping clinicians work on countertransference, self-care, and other issues.

Resources:

Seeking Safety: A Model for Trauma and/or Substance Abuse

www.seekingsafety.org

COGNITIVE BEHAVIORAL INTERVENTION FOR TRAUMA IN SCHOOLS (CBITS)

Designed to: 1) Reduce symptoms of post-traumatic stress, depression, and behavioral problems, 2) Improve functioning, grades, attendance, peer and parent support, and coping skills.

Components:

- Includes 10 group sessions; 1-3 individual sessions; 2 parent psychoeducational sessions; 1 teacher educational session
- Cognitive-behavioral techniques include psychoeducation, relaxation, social problem solving, cognitive restructuring/how to challenge upsetting thoughts, and exposure/processing traumatic memories.

Resources:

Cognitive Behavioral Intervention for Trauma in Schools

http://cbitsprogram.org

SOMATIC EXPERIENCING (SE)

Designed to: 1) Complete the initiated survival responses unable to be completed at initial time of trauma, and discharge the neurological memory stored in the peripheral nervous system, 2) Restore self-regulation, resilience, equilibrium, and a sense of wholeness.

Components:

- Nine Step Method for Transforming Trauma including:
  1. Create an environment of relative safety.
  2. Support initial exploration of touch sensations including pendulation and titration.
  3. Pendulation: rhythm of contraction and extraction.
  4. Titration: survival based arousal.
  5. Provide corrective experiences.
  6. Uncouple fear from immobility; contain sensation of hyper-arousal.
  7. Discharge and regulate hyper-arousal states.
  8. Engage in self-regulation to restore dynamic equilibrium and relaxed alertness.
  9. Reorient in the here and now.

Resources:

Somatic Experiencing Trauma Institute

http://www.traumahealing.com/somatic-experiencing/index.html

NEUROSEQUENTIAL MODEL OF THERAPEUTICS

Designed to: Structure assessment of child/youth, articulate primary problems, identify key strengths, and apply interventions (educational, enrichment, and therapeutic) to help family, educators, therapists and related professionals best meet the needs of the child.

Components:

- The NMT process helps match the nature and timing of specific therapeutic techniques to the developmental stage of the child/youth, and to the brain region and neural networks that are likely mediating the neuropsychiatric problems.

Resources:

Child Trauma Academy

http://childtrauma.org/index.php/articles/cta-neurosequential-model

MANY MEDICINES:

TRUAMA-INFORMED EVIDENCE-BASED BEST PRACTICES AND PROMISING APPROACHES (PAGE 4 OF 6)

MINDFULNESS

Designed to: 1) Strengthen concentration and increase capacity to focus, 2)

Decrease stress & anxiety and increase sense of calm, 3) Improve immune response and general health.

Components:

Mindfulness activities build skills in:

- Emotional intelligence
- Self-awareness
- Impulse control
- Empathy
- Conflict resolution

Trauma Considerations for Working with Youth:

Be aware that increasing one's awareness of bodily sensations, emotions, and thoughts can potentially be overwhelming to a youth who has experienced trauma.

- Start with simple, non-threatening mindfulness exercises (e.g., focusing awareness on an object in the hand, and if teaching meditation, suggesting only to close eyes if comfortable or look down at a spot in front of them).
- Proceed in a slow, step-wise manner, and check in frequently with youth to ensure that youth feels safe and supported.
- Ensure non-judgmental acceptance of wherever youth is with mindfulness practice.

If youth becomes overwhelmed or triggered, stop the exercise, help youth calm down, then re-evaluate with youth how best to proceed.

Resources:

1. Mindful Schools
   http://www.mindfulschools.org/
2. Mind Body Awareness Project
   http://www.mbaproject.org/
3. Applied Mindfulness
   http://www.applied-mindfulness.org/
4. John Briere Mindfulness Materials
   http://www.johnbriere.com/Mindfulness%20materials.htm

HEALTHY DRUMMING

Designed to: 1) Bridge mind, body, and spiritual realms of self, 2) Decrease stress and anxiety, 3) Induce an awakened and reflective state of consciousness.

Components:

- Participants play basic intuitive rhythmical patterns on a drum, vocalizations, breathing exercises, meditation, and verbal and non-verbal communication.
- Medicinal drumming circles are not music classes and are not focused on learning any traditional rhythms or percussive patterns.

Resources:

Healthy Drumming

http://healthydrumming.org/home.html

HEALING HISTORICAL TRAUMA

Designed to: 1) Increase awareness of unconscious sources of grief and anger, 2) Reclaim traditional mourning, grieving rituals, and ceremonies.

Components:

- Confronting the trauma and embracing history.
- Understanding the trauma.
- Releasing the pain.
- Transcending the trauma.

Resources:

Native American Center for Excellence
http://nace.samhsa.gov/HistoricalTrauma.aspx

MANY MEDICINES

TRUAMA-INFORMED EVIDENCE-BASED BEST PRACTICES AND PROMISING APPROACHES (PAGE 5 OF 6)

NATIONAL CHILD TRAUMATIC STRESS NETWORK (NCTSN)

Designed to: Improve access to care, treatment, and services for traumatized children and adolescents exposed to traumatic events.

Components:

- National Center for Child Traumatic Stress : works with the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop and maintain the Network structure, provide technical assistance to grantees within the Network, oversee resource development and dissemination, and coordinate national education and training efforts.
- Treatment and Services Adaptation Centers : Provide national expertise on specific types of traumatic events, population groups, and service systems and support the specialized adaptation of effective treatment and service approaches for communities across the country.
- Community Treatment and Services (CTS) Centers : Implement and evaluate effective treatment and services in community settings and youth-serving service systems and collaborate with other Network centers on clinical issues, service approaches, policy, financing, and training issues.

Resources:

http://www.nctsn.org

2012 ATTORNEY GENERAL'S TASK FORCE ON CHILDREN EXPOSED TO VIOLENCE

Designed to: Address epidemic levels of exposure to violence faced by our nation's children.

Components:

- Based on public hearing testimony, comprehensive research, and extensive input from experts, advocates, and impacted families and communities nationwide, the final report includes findings and comprehensive policy recommendations to serve as a blueprint for preventing and reducing children's exposure to violence across the United States.

Resources:

http://www.justice.gov/defendingchildhood/index.html

CORE CURRICULUM ON CHILDHOOD TRAUMA

Designed to: 1Expand the nationwide mental health workforce including graduate training programs in social work, psychology, medicine, nursing, marriage and family therapy, and related fields to incorporate trauma-focused approaches to care including strength-based treatment plans that aim to both reduce distress and dysfunction, and promote wellness and positive youth development.

Components:

Basic training for practitioners who lack experience in trauma-focused work and a resource for the continuing education of experienced practitioners to broaden and refine areas of expertise, including:

1. Core Concepts: Basic principles and knowledge regarding trauma-focused treatment including psychoeducation and coping skills.
2. Core Components: Basic treatment elements of trauma- focused treatment including balance between advantages of adhering to a manualized treatment protocol with advantages of tailoring interventions to reflect the specific needs, strengths, and living circumstances of each youth and family.
3. Core Skills: Essential clinical proficiencies in trauma-focused treatment including case conceptualization that centers on empathetic understanding of youth's life and individual trauma experience, rather than only on symptom profile or type of trauma exposure.

Resources:

The National Center for Child Traumatic Stress (NCCTS)

http://www.nctsn.org/resources/audiences/parents-caregivers/what-is-cts/12-core-concepts

MANY MEDICINES

TRUAMA-INFORMED EVIDENCE-BASED BEST PRACTICES AND PROMISING APPROACHES (PAGE 6 OF 6)

NATIONAL CENTER FOR TRAUMA-INFORMED CARE

Designed to: Build awareness of trauma-informed care and promote the implementation of trauma-informed practices in programs and services.

Components:

- Training for staff, leaders, and consumers on the implementation of trauma-informed care in a range of service systems, including mental health, substance abuse, criminal justice, victim assistance, peer support, education, primary care, domestic violence, and child welfare.
- Training is offered either in brief sessions to diverse meeting or conference audiences or over several hours or days to specific programs or agencies.
- Technical assistance and consultation to support systems and programs that are committed to implementing trauma-informed approaches to service delivery.
- Technical assistance helps to identify and implement some of the steps that programs, agencies, or institutions can take to begin the transformation to a trauma-informed environment.

Resources:

National Center for Trauma Informed Care

http://www.samhsa.gov/nctic/default.asp

ACES TOO HIGH

Designed to: Be the go-to site for the general public on news and information about ACEs epidemiology, the neurobiological effects of toxic stress, epigenetics, biomedical effects of ACEs, and how schools, cities, states, agencies, and organizations are implementing trauma-informed practices.

Components:

- Research: Links to current research.
- Resources: Links to useful presentations, backgrounders, reports, and ACE concepts in the news.
- ACEs in Action: Links to projects and programs.
- Our Stories: A place where people can tell their personal stories about how child trauma affected their lives and health.

Resources:

http://acestoohigh.com

AMERICAN ACADEMY OF PEDIATRICS (AAP) MEDICAL HOME FOR CHILDREN EXPOSED TO VIOLENCE

Designed to: Provide pediatricians and all medical home teams with the resources they need to modify practice operations to more effectively identify, treat, and refer children and youth who have been exposed to or victimized by violence.

Components:

- Educational Opportunities: Meetings, webinars, and resources from past events.
- Best Practices and Quality Improvement: Support for ongoing improvement of care within the medical home model.
- Vignettes: Demonstrations in clinical settings to consider exposure to violence as a differential diagnosis.

Resources:

http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Medical-Home-for-Children-and-Adolescents-Exposed-to-Violence/

ACES CONNECTION

Designed to: Be the companion social network to ACEsTooHigh.com for individuals who are implementing, or thinking about implementing practices based on ACE and trauma-informed concepts.

Components:

- Members can post information (text posts, photos, videos, events) directly to the site, "friend" and message others who are doing things of interest, and form groups around interests.

Resources:

http://acesconnection.com

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ADOLESCENT HEALTH WORKING GROUP, 2013

AHWG

www.ahwg.net