

Sanctuary Plus (IRIS Project)

<p style="text-align: center;">Program Description</p>	<p>Sanctuary® Plus combines trauma-sensitive training (START) and a model for organizational change (Sanctuary®) to develop a safe, supportive, therapeutic community. The model includes a structured protocol (Real Life Heroes) for engaging children and caring adults with creative arts to develop the nurturing relationships necessary for trauma processing, rebuilding (or building) attachments, developing strength-based beliefs and affect regulation skills, and returning children and adolescents to family living. Sanctuary® Plus brings together these three models and implements components of evidence-based practices through community meetings, trauma-based psycho-educational groups, life story work, and trauma-informed staff working together with youths and families to develop effective social, affect management, and cognitive skills, to develop and implement safety plans for children in their homes and at the residential treatment center, and to reduce PTSD symptoms including aggressive and dangerous behaviors that necessitated residential placement.</p>
<p style="text-align: center;">Target Population</p>	<p>Children and adolescents placed in residential treatment centers and their families</p>
<p style="text-align: center;">Essential Components</p>	<p>Sanctuary® Plus integrates a model of organizational change (Sanctuary®), a trauma-informed, training-reorientation curriculum (START), and an activity-based life story approach to rebuilding attachments, establishing permanency, and reprocessing traumas (Real Life Heroes). Institutions are encouraged to build on children’s strengths, the needs and the strengths of each institution, and a commitment to nonviolent, democratic values.</p>
<p style="text-align: center;">Trainings & Program Material</p>	<p>Integrated training is planned to condense a current nine-day program that includes START, Real Life Heroes, and Sanctuary with follow-up biweekly consultation. Program materials include <i>Real Life Heroes Practitioner’s Manual</i>, <i>Real Life Heroes Life Storybook</i>, detailed curriculum for START, and the training program and group activities for Sanctuary®. A training manual and guide books for Sanctuary® will be available by 8/05. Published references are available for Sanctuary and Real Life Heroes.</p>

<p>Outcomes/ Evaluation</p>	<p>Integrated model currently being tested at Parsons. Research findings available on Sanctuary from studies at the Jewish Board of Family and Children’s Services demonstrated effectiveness, and replications at Andrus and Parsons showed significant reductions in critical incidents and staff turnover reported at Andrus. Initial evaluations of START and Real Life Heroes have shown positive results.</p>
<p>Replications</p>	<p>Planned but not yet implemented.</p>
<p>Anecdotal Observations</p>	<p>Strong interest from several residential treatment centers (RTC) in the NCTSN and the RTC Working Group. Great enthusiasm at Parsons for development and implementation leading to rapid implementation in the RTC and also the Hellman school. Providing START training to staff greatly expedited training and commitment to adding the Sanctuary model. Participation in Sanctuary training, in turn, facilitated work by clinical and child care staff utilizing the Real Life Heroes curriculum.</p>
<p>Program Developers</p>	<p>Robert Abramovitz, Joe Benamati, Sandra Bloom, Karen Clark, David Cook, Brian Farragher, John Hornik, Richard Kagan, David McCorkle, and Caroline Peacock</p>
<p>Contact Information</p>	<p>Richard Kagan, PhD Parsons Child Trauma Study Center 60 Academy Rd. Albany, NY 12208 (518) 4262600 e mail: kaganr@parsonscenter.org</p>

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Real Life Heroes

<p>Program Description</p>	<p>Real Life Heroes utilizes an activity-based workbook to help traumatized children build the skills and interpersonal resources needed to reintegrate painful memories and to foster healing after abuse, neglect, family violence, severe illness, death, or losses.</p>
<p>Target Population</p>	<p>School-age children, early adolescents, and caring adults who have experienced losses, family violence, disasters, severe and chronic neglect, physical and sexual abuse, repeated traumas, and “post-traumatic developmental disorder.” In addition, children in, or at risk for, placement in foster family care, residential treatment, detention centers, psychiatric hospitals, as well as families working in adoption counseling. Children typically present with anxiety, depression, PTSD, disruptive behaviors, sexualized behaviors, and functional impairment in multiple areas.</p>
<p>Essential Components</p>	<p>The life storybook (built around the metaphor of heroes) provides a structured, phased-based approach to help children and caring adults rebuild safety, hope, attachments, skills, and resources necessary for trauma therapy. Creative arts activities are utilized to develop affect recognition, regulation skills, and constructive beliefs. Components also include psychoeducation on trauma, attunement and trust with caring adults, problem solving skills, and the resources needed for trauma processing, desensitization to triggers, and sharing a coherent life story including a past, present, and future. The model engages caring adults to validate children by building on family strengths, fostering an understanding of trauma, reducing shaming/blaming, and strengthening each child’s cultural heritage. The intervention involves four-to-eight months of weekly therapy sessions (one session per week for a total of 32 hours).</p>
<p>Trainings & Program Material</p>	<p>Clinicians (typically MSW) attend a two-day workshop and participate in consultation groups every other week. Childcare staff and foster parents are also involved in training as team members and caring adults. Training materials include a life storybook for both children and caring adults and a practitioner manual that includes key objectives, an overview, step-by-step guidelines, checkpoints (essential elements), and troubleshooting tips to get unstuck for each chapter. A session summary/progress note and a bookmark (reminder list) are provided to help practitioners incorporate key components and sequence into sessions. Program has been running since 1998.</p>

<p>Outcomes/ Evaluation</p>	<p>A pilot study (single group, pre-post comparison) will be completed by 6/05 with 17 practitioners and 42 children (ages 7–14) to study the effectiveness of the program. Children and guardians meet with an interviewer four times, at the beginning of treatment, and then at 4, 8, and 12 months into therapy as well as after sessions end. Preliminary results indicate that the model helps clinicians to persevere with consistent application of cognitive behavioral therapy components over time with crisis-oriented children and families. Together, the combination of visual, auditory, movement, and narrative modalities with a structured curriculum appears to promote a sense of mastery and skills as measured by an increase in self-control ratings and a decrease in perceptions of distress.</p>
<p>Replications</p>	<p>The model is being tested at several other community practice sites of the National Child Traumatic Stress Network, including a replication study that is just beginning.</p>
<p>Anecdotal Observations</p>	<p>Program appears to be related to a reduction in trauma symptoms, PTSD symptoms, and negative behaviors. In addition, participants have been observed to demonstrate behaviors associated with increased attachment, trust, and affiliation. Use of nonverbal creative arts modalities has been helpful as a precursor to asking children to utilize words.</p>
<p>Program Developer</p>	<p>Parsons Child Trauma Study Center</p>
<p>Contact Information and Website</p>	<p>Richard Kagan, PhD Parsons Child Trauma Study Center 60 Academy Road Albany, N.Y. 12208 (518) 426-2600 Ext 2725 kaganr@parsonscenter.org www.parsonscenter.org/</p>

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PARSONS Child Trauma Study Center

Towards Evidenced-Based Practice: Real Life Heroes By John Hornik, Ph. D.

A major research collaboration between Parsons Child Trauma Study Center and Advocates for Human Potential (AHP) is showing some early positive results. Preliminary findings indicate that after four months of receiving the *Real Life Heroes (RLH)* intervention, clients are showing significant reductions in symptoms of post-traumatic stress, improved behavior at home, and increased hopefulness among children.

RLH was developed by Richard Kagan, Ph.D., as an activity-based workbook and curriculum geared to helping traumatized children build the skills and interpersonal resources needed to re-integrate painful memories and to foster healing after abuse, family violence, severe illness, death, or other losses. Utilizing creative arts and life story work children and caring adults are helped to recognize family and/or community heroes, to develop skills to identify and express feelings, to modify child's perception of personal history by strengthening positive memories, and to develop child's capacity to cope with past, present, and future stressors.

Seventeen clinicians from the Parsons Prevention, Therapeutic Foster Care, Residential services and outpatient treatment programs elected to offer the treatment approach to select children. At study onset, 41 children, primarily between the ages of 8 and 12 agreed to participate in the study. The mean age of the children was 10.5, 41% were female, 53% were members of an ethnic minority group, and 36% were living out-of home.

Demographic, behavioral, interpersonal, cognitive, and symptomatic information was collected at preset intervals through the use of checklists; session summaries; and inventories from children, their primary caregivers, and clinicians.

At newsletter publication, preliminary data from baseline to four months of collection suggests that children utilizing the *RLH* approach have demonstrated reduced trauma symptoms on both child self-reports and caregiver reports, fewer problem behaviors on caregiver checklists, and increased hope on self reports. In addition, preliminary results have also indicated that the model helps clinicians to persevere with consistent application of cognitive behavioral therapy components over

time. Children will be followed for one year after beginning treatment.

Use of nonverbal creative arts modalities also appear to be helpful as a precursor to asking children to utilize words based on anecdotal reports in pilot testing. Together, the combination of visual, auditory, movement, and narrative modalities with a structured curriculum appears to promote a sense of mastery and skills as measured by an increase in self-control ratings and a decrease in perceptions of distress from the beginning to end of sessions.

Children and parents have noted how the curriculum has fostered self-control and increased feelings of attachment. For example, one boy reported "I have so many more people in my life that can help me now. I am not alone anymore." A girl listed her (*RLH*) workbook as the most important thing she would want to take out of her house if there was a fire.

Upon completion of both the Real Life Heroes study in the fall of 2005, and the analysis of data collected, we will continue to update you on what we anticipate will be further treatment successes of this innovative treatment modality. This study was funded by a grant from the U.S. Center for Mental Health Services under the National Child Traumatic Stress Initiative, Joseph Benamati, director, and Richard Kagan, principal investigator. The study of (*RLH*) is conducted by John Hornik, Ph.D., Amber Douglas, Ph.D. and Suzannah Kratz, M.Ed., all of AHP.

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DIRECTOR'S CORNER

Joe Benamati

An Interview with Sandy Bloom

Dr. Sandra Bloom, distinguished fellow at the Andrus Center for Learning and Innovation, served as the Executive Director of Sanctuary programs from 1980-2001. Dr. Bloom has devoted her clinical work and practice to the development of safe environments for the treatment of adults who have been abused as children. Her first book, *Creating Sanctuary: Toward the Evolution of Sane Societies*, is devoted to the story of her experiences developing inpatient programs for traumatized adults. She is past president of the International Society for Traumatic Stress Studies (ISTSS), past president of Philadelphia Physicians for Social Responsibility, and served as chair of the Task Force on Family Violence for the Pennsylvania Attorney General.

In 2000 the National Institute of Mental Health (NIMH) awarded a research grant to study the introduction of the Sanctuary Model into residential treatment programs for traumatized children and adolescents in New York State. The study yielded positive results including a reduction of client symptomology and improvements in organizational culture. Dr. Bloom along with David McCorkle and Brian Farragher of Andrus Home introduced the concepts of Sanctuary at Parsons Child and Family Center in January 2004 and have been our guides and mentors since that time.

[Acknowledgement goes to Ms. Shelley Murphy (NYS OCFS) who prepared many of the questions for Dr. Bloom]

Trauma Center: Can you help us understand what is meant by trauma?

Bloom: A person experiences something as traumatic when both their internal and their external resources fail (van der Kolk). Internal resources represent everything from the way the body manages stress, to the meaning the person makes of the event. External resources are represented by everyone else – family, friends, community, and society-at-large. If internal resources are adequate to meet the danger, then the central nervous system is sufficiently buffered that there are unlikely to be long-term consequences. If internal resources fail but external resource remain intact and are therefore able to offer the kind of protection the person needs and that also serves as a buffer for the central nervous system – as so often happens to children when their families protect them – then the person may also not suffer long-term problems. If both internal AND external resources fail, the likelihood of long-term, physiological damage is greatly increased.

Trauma Center: Do traumatic events impact children and adults differently?

Bloom: Traumatic events can impact children and adults very differently. The central nervous system- the brain – of children are far more vulnerable than those of adults and this is why children need so much protection. Children are relatively helpless in the world and must depend on, and trust, adults to care for and protect them. Children do not have enough experience with the world to differentiate between things that are dangerous and those that are not; people who are trustwor-

thy and those who are not. They are unable to put their experience into context or make sense out of what happens to them. And, perhaps most importantly, children are developing at an exceedingly rapid rate – in mind, body, and identity. As a result of this rapid development, they are sensitive to events that may not necessarily have the same impact on an adult.

Trauma Center: When you say children are developing rapidly in mind, body, and identity can you elaborate on what this means for the child? Is it possible to mistake the behaviors that result from trauma for something else?

Bloom: Sadly, these kinds of mistakes happen all the time for several reasons. In the first place, the effects of trauma look like so many other problems, particularly when there is a prolonged interval between the traumatic event(s) and the presentation of symptoms to a helper. Trauma experienced in childhood is particularly likely to be transmuted over time into substance abuse problems, sexual addiction, chronic depression, physical disorders, and a variety of personality disturbances, and victims are unlikely to make any connection between the present problems in their lives and the long-ago history of abuse or neglect. If they do remember the things that happen to them – and they may not because of the protective mechanism known as “dissociation” - they may be reluctant to re-experience the pain of the past, or ashamed, or continue to feel a need to protect their families of origin. In the second place, people in service professions are generally reluctant to ask about traumatic experience and its connection to present problems because they haven’t been educated about the connections and do not know what to ask, or because they don’t want to know because they feel it’s like “opening Pandora’s box,” or because the traumatic experience of the other person reminds them too closely of things that have happened to them.

Trauma Center: How does trauma relate to the foster care experience in general?

Bloom: It is critically important that child welfare workers, domestic violence advocates, child advocates, and foster care workers – and families – understand the impact of traumatic experience and the multigenerational nature of disrupted attachment that goes along with trauma because it is inevitably playing a significant role in the problems that children and their families present. The presence of a history of abuse in the lives of abusive parents presents workers with complex conundrums for child welfare workers that have yet to be fully explored, understood or responded to. The trauma explanations help make incomprehensible behavior far more comprehensible and it becomes much easier to understand the nature of “resistance,” and yet the reality is, children still need to be protected. But, they need to be protected from further trauma AND from disrupted attachment. This makes simple answers impossible. The challenges that lie ahead for child welfare is to take the opportunity to process what exactly all this trauma information means to the field, to the way services are delivered, to the nature of those services, to the way traumatized individuals change, and to the kinds of services that promote healing and resolution rather than further trauma – for the parents and for the children. For foster care providers, the trauma knowledge is also critical and significantly helps to explain why simply moving a traumatized child to a healthy home frequently fails to actually change him/her and more commonly, the healthy home

is often traumatized by this child. Only in understanding traumatic reenactment and how to reshape that behavior can foster families hope to bring about the changes they long for. Many of the responses necessary to help traumatized children are counter-intuitive and without understanding the impact of trauma on these children providers and helpers may actually do things that bring about more harm rather than help.

Trauma Center: Is trauma also significant for the juvenile justice field? Is the result or impact of trauma different for a child or a young person who commits violence, as opposed to the victim of that violence?

Because the criminal justice field focuses so much on retribution rather than rehabilitation these days, our understanding of the ways in which traumatic experience interfaces with the provision of services in juvenile justice lags behind even the mental health field, where trauma understanding is still in its infancy. Research has demonstrated that juveniles who commit violence are usually victims of violence, as are the adults these children eventually become. Unfortunately, the environments these people are placed in for punishment often create further traumatization. Perpetrators of violence have usually been victims of violence: "hurt people hurt people." We don't yet fully understand what determines a child's course; why some hurt themselves, some hurt other people, and some manage not to hurt anyone. It is safe to say, that creating a trauma-informed justice system is revolutionary and profoundly important if we are ever to stop the endless cycling of victim to perpetrator.

Trauma Center: Should an increased awareness of trauma impact the way we work with children and families?

Bloom: Learning about trauma represents a different "paradigm" and challenges many of the established truths and practices that we all learned in our professional training, regardless of what school we attended. To use the knowledge every individual first has to acquire it – and that cannot come about through a one hour talk. If you don't feel challenged and even threatened by this material, then you probably aren't really taking it in yet. Before we can use it effectively with our clients, workers in the field, and particularly leaders in every organization must acquire the knowledge, teach the knowledge, and debate with each other over the implications of what it means for every field of endeavor. Only then are we in a position to use the knowledge with children and families. Using it first means taking them through the same process of deep psychoeducation which eventuates in the shift in fundamentals, a shift from "What's wrong with you?" to "What happened to you?" The trauma knowledge shifts our basic mental models for how we understand ourselves and other people, and eliminates the blaming and shaming attitude that is so much a part of our culture, and puts in their place understanding, compassion, and the expectation of shared responsibility. It also carries with it a redefinition of the meaning of safety, an emphasis on the achievement of emotional management, the development of methods to help resolve grief, and an emphasis on change, growth, and the ability to avoid recreating a traumatic past. Healing from trauma is complex but entirely possible for children and for their parents, but it does not happen rapidly, it goes in stages with frequent relapse periods at first, and it requires resources that include time, money, people, and love in its broadest

sense.

Trauma Center: Can you describe the common elements of a trauma-sensitive treatment program for children?

Bloom: Many methods and innovative approaches are being tried and evaluated. Some common elements include: 1) an emphasis on safety, 2) the integration of cognitive and emotional components, 3) an emphasis on skill-building and self management of emotional states, 4) rebuilding of trusting and safe relationships, 5) psychoeducation about the impact of trauma, 6) making sense out of experience and transforming pain through many kinds of change including those fostered by creative expression, and 7) developing some kind of "survivor mission" – putting one's painful past experiences at the service of the greater good.

Trauma Center: As usual, it's been a pleasure speaking with you and learning from you. We hope that Parsons relationship we share with (Bloom, Farragher, McCorkle) continues to grow and produce results for children and their families.

Bloom: It is really a pleasure to work with staff (Parsons) that are committed to providing a safe and therapeutic environment for traumatized kids. I'm sure our relationship will continue to grow and produce good results for children.

Joe

Resource Library

Van der Kolk, B. (2005) 'Child abuse & victimization: treating complex trauma in children and adolescents.'
Psychiatric Annals 35, 5.

This edition includes guest editor, Bessel van der Kolk, renowned traumatologist. Richard Kagan Ph.D., Parsons Child Trauma Study Center's clinical director has contributed to this edition. Some of this volumes features include:

- *Child Abuse & Victimization*, by Bessel van der Kolk, M.D.
- *Complex Trauma in Children and Adolescents*, by Alexander Cook, Ph.D.; Joseph Spinazzola, Ph.D.; Julian Ford, Ph.D.; Cheryl Lanktree, Ph.D.; Margaret Blaustein, Ph.D.; Marylene Cloitre, Ph.D.; Ruth DeRosa, Ph.D.; Rebecca Hubbard, L.M.F.T.; Richard Kagan, Ph.D.; Joan Liautaud, Psy.D.; Karen Mallah, Ph.D.; Erna Olafson, Ph.D., Psy.D.; and Bessel van der Kolk, M.D.
- *Treatment Implications of Altered Affect Regulation and Information Processing Following Child Maltreatment*, by Bessel van der Kolk, M.D.

Much more is included in this volume. For a complete index, or if you are interested in any of these publications contact the trauma library at (518) 426-2849.

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Traumatic Stress Network

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Trauma Links

www.practicenotes.org

This website explores ways child welfare practitioners can recognize PTSD and respond in an appropriate, timely way when encountered.

www.ptsdalliance.org

The PTSD Alliance is a group of professional advocacy organizations that have joined together to educate individuals with PTSD and their loved ones; medical, and health care professionals.



Parsons Child and Family Center

Parsons Child Trauma Study Center

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Sanctuary® Model

Program Description	<p>The Sanctuary® Model, derived from an adult program with a 22-year history, seeks to create a global change in climate for children and adolescents in a residential care setting. Sanctuary® is based on four main methods: social learning theory, trauma theory, nonviolence, and complexity theory. Two core components are the creation and maintenance of a nonviolent, democratic, therapeutic community and psycho-educational exercises and modules that promote a common language for staff and residents to use when discussing the impact of trauma on the resident.</p> <p>The program is meant to apply to a broad range of traumatized and troubled children and is organized around four core tasks associated with recovery: the ability to (1) maintain Safety; (2) manage Emotions, and (3) deal with Loss, in conjunction with (4) envisioning a better Future - which are summarized in the acronym S.E.L.F. The program structure seeks to involve staff at all levels in working on these tasks. The program is transformative both for children and staff and can be introduced into existing residential settings in a progressive fashion.</p>
Target Population	<p>Age ranges from six years to early adulthood. The program serves all types of trauma through its generalized focus on the S.E.L.F. tasks described above.</p>
Essential Components	<p>An essential element of the model is the creation of a set of shared assumptions that span all levels of staff and administration. These include (1) a set of core values, (2) a “flattening” of the decision-making hierarchy, (3) the inclusion of all levels of staff input in treatment decisions, (4) a team focus on trauma-history-related treatment, (5) power sharing among staff, (6) the importance of safety in the healing process, (7) a recovery model based on the S.E.L.F. tasks, and (8) twice daily “community meetings” to maintain the shared focus on safety and S.E.L.F.-related daily goals. The treatment focus is on “what happened to the child” and not on the child’s behavior.</p> <p>The program is organized around groups, teams, and units and has a strong psycho-educational component about the impact of trauma and the phased nature of recovery. Staff members at all levels are considered important in the recovery process and receive training in intervention skills. Training strongly emphasizes role playing and other experiential methods. A major intervention focus is affect regulation.</p>

<p>Trainings & Program Material</p>	<p>Staff at all levels are considered important in the recovery process and receive training in intervention skills. Training strongly emphasizes role playing and other experiential methods. A major intervention focus is affect regulation. Staff can have a HS diploma or higher education—all receive common trainings in basic trauma treatment and behavioral management skill sets.</p>
<p>Outcomes/ Evaluation</p>	<p>An NIMH R21 outcome evaluation grant (PI Jeanne Rivard, PhD) utilizing a random assignment design to either a Sanctuary® unit or standard residential services was performed from 2000 to 2003. Data was collected at five points. The findings have been published in a variety of juried publications. Preliminary data analysis reveals significant trend improvements in verbal aggression, locus of control, incendiary communication, and significantly improved tension management.</p>
<p>Replications</p>	<p>The original adult Sanctuary® model was initially adapted for an adolescent residential setting at the Jewish Board of Family and Children’s Services (JBFCs) residential treatment programs followed by its implementation at Andrus Children’s Center and Parsons Child and Family Services. The Sanctuary® Model is now being implemented at the schools associated with the JBFCs residential treatment programs, and at the on-campus day treatment program.</p>
<p>Anecdotal Observations</p>	<p>The flexible nature of the program and the progressive nature with which it can be implemented over time at a given site allow it to take hold in an established setting and transform the care-giving environment. Significant shifts in cross-disciplinary communication and work satisfaction have been observed.</p>
<p>Program Developer</p>	<p>The adult model developed by Sandra Bloom, MD, director of Community Works, was adapted for children and adolescents in residential treatment in collaboration with the JBFCs Center for Trauma Program Innovation in New York City beginning in 1998.</p>
<p>Contact Information</p>	<p>JBFCs Robert Abramovitz (212) 632-4665 Caroline Peacock (914) 773-7374 Andrus Children’s Services Brian Farragher (914) 965 3700 X1242 Parsons Child and Family Center Joseph Benamati (518) 426 2661 Community Works Sandra Bloom (888) 538 3124</p>

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Risking Connections

Staff development curriculum originally developed for use in the field of mental health services was revised for use in the field of juvenile justice

Understanding Trauma

- What is psychological trauma?
- Biological underpinnings of trauma
- Who are our survivor residents?
- What people learn in abusive relationships
- How to work effectively and well with survivor clients
- Using a theoretical framework: CSDT (Constructivist Self Development Theory)

Basic Assumptions

- Symptoms are adaptations
- Trauma shapes the survivor's basic beliefs
- Four important components (RICH) (Respect Information Connection Hope)
- Treaters need support
- Working with survivor residents affects the helper

Survivors Are Individuals...

...each survivor's response is unique

How Trauma Hurts

- Negative impact on feeling skills, self capacities
 - Managing feelings
 - Inner connection to others
 - Feeling worthy of life
- Judgment
- Beliefs
- Frame of reference
- Memory and perception
- Dissociation and memory
- Body and brain

Self-Awareness for the Helper

- Notice your experience
- What do you DO with these reactions
- How does noticing your reactions help your work?
- When can your reactions be a problem
 - Identification
 - Projection
 - Distancing
 - Denial

Vicarious Traumatization
Protecting Yourself

- Protection
- Awareness
- Balance
- Connection
- Connection to yourself
- Addressing stresses of vicarious traumatization
- Self-nurture
- Escape



National Childhood Traumatic Stress
Initiative

*"Preserving and restoring the future of America's
traumatized children"*

NCTSNet.org

National Childhood Traumatic Stress Network

- +_ 70 agencies nationwide
- Investigating effective trauma assessments and interventions
- Trauma exposure
 - Abuse, neglect
 - Medicalized
 - Man-made
 - Natural disasters
 - Terrorism
 - Traumatic Bereavement
 - Juvenile Justice/violence

NCTSN Workgroups

- RTC
- Family Court Judge curriculum (Osofsky)
- Systems Integration
- Traumatic Bereavement
- Pediatric Trauma Toolkit
- Policy Core (Raghavan)
- School (Wong) – Family Preparedness Card
- Foster Care (Kagan)

National Childhood Traumatic Stress Network

- Learning Collaboratives
 - TARGET (Ford)
 - TF-CBT (Cohen, Mannarino, & Deblinger)
 - STAIR (Cloitre)
 - PCIT (Olafson)
- Data Core
 - CBCL
 - TSCC
 - UCLA PTSD Index

What is TRAUMA?

- Trauma is an acute stress response that one experiences when confronted with **sudden, unexpected, unusual human experience**.
- Trauma occurs because the event **poses a serious threat to the individual's life** or physical integrity or to the life of a family member or close friend, or to one's surrounding environment.
- Individuals who may have witnessed the event are also at risk to develop a trauma stress response.
- Trauma produces overwhelming feelings of helplessness and hopelessness.

309.81 PTSD Criterion

- B. Persistent **re-experiencing**
 - B1. Recurrent and intrusive recollections
 - B2. Recurrent dreams during which the stressor is replayed
 - B3. Dissociative states during which parts of the event are re-lived
 - B4. Intense psychological distress
 - B5. Physiological reactivity

309.81 PTSD Criterion

- C. **Avoidance** of associated stimuli
 - C1. Avoids thoughts, feelings or conversations
 - C2. Avoids activities, situations, or people
 - C3. Amnesia of significant aspects
 - C4. Diminished responsiveness to the environment
 - C5. Feeling estranged from others
 - C6. Reduced ability to feel emotions
 - C7. Sense of foreshortened future

309.81 PTSD Criterion

- D. Symptoms of increased **arousal**
 - D1. Sleep disturbances
 - D2. Outbursts of anger
 - D3. Difficulty concentrating
 - D4. Hyper-vigilance

Complex Trauma

- Simultaneous or sequential occurrences of
- Emotional abuse and neglect
 - Sexual abuse
 - Physical abuse
 - Exposure to domestic violence
 - Community violence
 - Disrupts the child's security with primary caregivers
 - Experiences are chronic and typically begin in early childhood.

Characterized by:

- Unpredictable and inescapable violence
- Repeated abandonment
- Exacerbated by caregiver's difficulties with
 - Substance abuse
 - Mental illness
 - Family violence

Impact of complex trauma on:

- Brain development
- Learning difficulties
- Behavioral problems
- Emotional problems
- Disrupted attachment relationships

How do We Know if a Child is Experiencing Trauma?

- Formal Assessments
- Functional Assessment
- Observational Assessments

Observations
What to look and listen for

- Mood swings
- Increased irritability
- Headaches or chest pain
- Difficulty concentrating
- Uncontrollable crying
- Conflict in interpersonal relationships
- Nausea
- Nightmares or trauma-related memories that induce sweating or rapid heartbeat
- Anxiety over new events or routines
- Easily startled or timid behaviors

Normal Stress vs. Traumatic Stress

- Heart pounding
- Rapid breathing
- Muscles tense up
- Feel excited or worried
- Feel frustrated
- Feel determined
- Seeing/thinking clearly
- Considering options
- Acting rapidly
- Pensive
- Facing problems
- Taking on challenges
- Clear memories
- Creating solutions
- Feel angry
- Feel in control
- Feel good about yourself
- Heart feels like bursting
- Gasping, feeling smothered
- Muscles feel like exploding
- Feel terrified or panicked
- Feel doomed
- Feel aggressive
- Confused
- Mentally shut down
- Freezing
- Reflexive, instinctive
- Desperately avoiding
- Taking foolish risks
- Memory like a broken puzzle
- Making a mess of your life
- Feel enraged
- Feel helpless
- Feel worthless

Formal Assessments

- Trauma Symptom Checklist for Children (TSCC) (Briere)
- UCLA PTSD Index for Adolescents Revised
- Child Behavior Checklist (CBCL/Achenbach)
- Infancy and Early Childhood
 - Lieberman
 - Angie and Andy
- North Shore Compendium (Pelkovitz)

Trauma Symptom Checklist for Children (TSCC) - Briere

- 54/44-item
- Age: 8-17
- Assess:
 - Sexual abuse
 - Depression
 - Anxiety
 - Sense of Danger
 - Over/Under reporting
 - Posttraumatic Stress
- Multiple Reliability/Validity studies
- Computer-generated score

UCLA PTSD Reaction Index-R

- 22-item
- Age: 12-18
- Major syndromal characteristics of
 - Reexperiencing
 - Avoidance
 - Arousal

Self-administered: Group or Individual
Assess for: Presence of PTSD

Child Behavior Checklist for Ages 6-18

(Achenbach)

- Obtains reports from parents, other close relatives, and/or guardians
- Syndrome scores
 - Aggressive behavior
 - Anxious/Depressed
 - Attention Problems
 - Rule-Breaking Behavior
 - Social Problems
 - Somatic Complaints
 - Thought Problems
 - Withdrawn/Depressed
 - Affect
 - Anxiety
 - Somatization
 - Attention Deficit/Hyperactivity
 - Oppositional Defiant
 - Conduct
- Internalizing/Externalizing (Rivard Sanctuary study)

Assessment of Traumatic Stress in Infancy and Early Childhood

Alicia Lieberman, PhD C-San Francisco

- Multidimensional approach to assessment:
 - Child's Individual Functioning
 - Biological
 - Eating, sleeping, somatic complaints
 - Emotional regulation
 - Age-appropriate anxieties and coping
 - Social
 - Quality of attachment, peer relations
 - Cognitive
 - Developmental milestones, readiness to learn
 - Family Context
 - Community and cultural values

“Best Practice for Assessment”

-Lieberman

- 3-5 45-minute assessment sessions
- Developmental history before/after the trauma
- Observation of the child
- Observation of the parent-child relationship
- Child’s trauma narrative
- Collateral information

•The Angie/Andy Cartoon Trauma Scale

General Information:

combines questions and cartoon-based drawings to assess symptoms related to prolonged and recurring abuse young children may experience. The scale uses a thermometer response format. Both a long and short version of this scale exist.

Age: 6-12

Constructs Measured: Violence, Victimization

Method of Administration: Group and Individual

Subtests and Scores: Dysregulation of Affect and Impulses, Attention or Consciousness, Self-Perception, Relations with Others, Somatization, Systems of Meaning, Posttraumatic Stress.

Pelkovitz Trauma Assessment Compendium

- Analysis of 20+ trauma assessments
 - Syndromes measured
 - Population/demographics
- Use by professional/non-clinician
 - Reliability/Validity studies
 - Locator Information
- Sample questions/responses

Functional Assessments

- Eating
- Sleeping
- Concentrating
- Playing (trauma play)
- Attachment/lack of to others
- Thinking/Contrafactual
- Acting/Self-injurious/Risk-taking/Aggression

Review of Ten Findings in School Shootings

U.S. Secret Service & Wong

- Assessment of potential school shooters
- Interviewed all surviving shooters
- Recommendations and implications for school and community settings
- Predictive of possible school violence

Trauma Questionnaire for Adolescents

Benamati (2002)

Instructions: *Place a check mark in the box where it best reflects your feelings about each question.*

1. I avoid thinking about bad things that happened to me.
 2. I have trouble concentrating on things.
 3. I have dreams about the bad things that happened to me.
 4. I feel afraid whenever I think about the bad things that happened to me.
 5. When I have thoughts about the incidents I cannot control how my feelings are expressed.
 6. I feel like the same bad things are happening all over again.
 7. I get jumpy when I hear loud noises or when there is unexpected activity around me.
 8. I feel alone even when I am with my family and friends.
 9. I feel I will not have a normal life.
 10. I feel my life is in danger.
- Score each item: Never Sometimes Often Always

Parallel Process

*Complex interaction between
traumatized clients, stressed staff,
pressured organizations, and the social
and economic environment.*

Our systems frequently replicate the very
experiences that have proven to be so toxic
for the people we are supposed to treat.

Parallel Process!

Organizational Stress is a Barrier to Change

- Residential programs & the entire social service system are experiencing significant stress
 - **HOSTILE ENVIRONMENT & CONSTANT THREATS**
- In many organizations, neither the staff nor administrators feel particularly safe with their clients or even with each other
 - **LOSS OF BASIC SAFETY**

Organizational Stress is a Barrier to Change

- Atmospheres of recurrent or constant crisis severely constrain the ability of organization to:
 - involve all levels of staff in decision making processes
 - constructively confront problems
 - engage in complex problem-solving, or even talk to each other
- **LOSS OF AFFECT MANAGEMENT**

Organizational Stress is a Barrier to Change

- Communication networks break down under stress & service delivery becomes increasingly fragmented
 - **DISSOCIATION, FRAGMENTATION**
- When communication networks break down the feedback loops that are necessary for consistent & timely error correction break down as well
 - **SYSTEMATIC ERROR**
 - **MISPERCEPTIONS ABOUND**

Organizational Stress as Barrier to Change

- As decision-making becomes increasingly non-participatory and problem solving more reactive more short-sighted policy decisions are made that only compound existing problems
 - **LOSS OF DEMOCRATIC PROCESSES**
 - **LOSS APPRECIATION FOR COMPLEXITY**
 - **IMPAIRED COGNITION**
- Unresolved interpersonal conflicts increase and are not resolved
 - **IMPAIRED RELATIONSHIPS**

Organizational Stress is a Barrier to Change

- As the situation feels increasingly out of control, organizational leaders become more controlling, instituting more punitive measures in an attempt to avoid total chaos
 - **INCREASED AUTHORITARIANISM**

Organizational Stress is a Barrier to Change

- As the organization becomes more hierarchical there is a progressive isolation of leaders & a “dumbing down” of staff
 - **DISEMPOWERMENT, HELPLESSNESS**
 - **LOSS OF CRITICAL THINKING SKILLS**

Organizational Stress is a Barrier to Change

- Staff respond to the perceived punitive measures instituted by leaders by acting-out and passive-aggressive behaviors
 - **INCREASED AGGRESSION**
- Standards of care deteriorate & quality assurance standards are lowered in an attempt to deny or hide this deterioration
 - **UNRESOLVED GRIEF**

Organizational Stress is a Barrier to Change

- Over time, leaders and staff lose sight of the essential purpose of their work together & derive less satisfaction & meaning from the work
 - **LOSS OF MEANING & HOPE**

Organizational Stress is a Barrier to Change

- When this spiral is occurring, staff feel increasingly angry, demoralized, “burned out”, helpless & hopeless about the people they are working to serve & the work in general
 - **DEMORALIZATION**
 - **HOPELESSNESS**

Organizational Stress is a Barrier to Change

- If this destructive sequence is not arrested, the organization begins to look & act in uncannily similar ways to the traumatized clients it is supposed to be helping
 - **SELF-DESTRUCTIVE BEHAVIOR**
 - **FORE-SHORTENED FUTURE**
 - **LOSS OF CREATIVE PROBLEM-SOLVING**
- **The Result.....**

**ORGANIZATIONAL
COMPLEX PTSD**

**Parallel Process
Trauma Symptoms**

- **In Our Kids:**
 - Reluctant to Discuss Traumatic Past
- **In Our Staff & Programs:**
 - Assessment Does Not Take Trauma History Into Account, When it Does It is Quickly Forgotten or Discounted
 - Symptoms Become the Entire Focus Not the Pain Behind the Symptoms

**Parallel Process
Trauma Symptoms**

- **In Our Kids:**
 - Increased Aggression
- **In Our Staff & Programs:**
 - Increase Coercion, Seclusion, Restraint, Restrictions, Blaming

Parallel Process
Trauma Symptoms

- **In Our Kids:**
 - Hyper arousal
- **In Our Staff & Programs:**
 - Running From Crisis to Crisis
 - Lack of Planning
 - Managing Like Your Hair is on Fire

"If you don't change your beliefs, your life will be like this forever. Is that good news?"

~ Dr. Robert Anthony
Educator & Writer

Each Level Can Positively or Negatively Impact the Other

Helping Children to Change & Grow Requires Change & Growth In the Staff & In the System!!

Creating Sanctuary = Resolving Trauma
Offering an Alternative Reality

- Commitment to Nonviolence
- Commitment to Emotional Intelligence
- Commitment to Social Learning
- Commitment to Democracy
- Commitment to Open Communication
- Commitment to Social Responsibility
- Commitment to Growth and Change

SELF

- S = Safety
- E = Emotions
- L = Loss
- F = Future

Sanctuary Model

- Organizations respond to stress in many of the same ways clients do
- Organizations under chronic stress can look like kids under stress and here's how and why
- How do organizations begin to protect themselves, their staff & their clients from the impact of repetitive stress?
- What is the role of Commitments and SELF in building in these protections and changing the organizational culture?

“A parent is only as happy as their least happy child.”

- Yiddish proverb

“A team is only as effective as its least effective member.”

- Not a Yiddish proverb

Why START?

- Staff focus on symptomatic problems and current crises.
- Therefore, most training tends to focus on symptomatic solutions

Result

Staff have an incomplete understanding of the clients they are serving

START

- +600 direct care staff trained
- 10 sites in 4 States
- START Brief Version: +400 DCS in 10 States (Nov 2005)
- Pre-Post Measurement

START

Systematic Training to Assist in the Recovery from Trauma

- Developed specifically for direct care staff
 - Residential Treatment Centers (RTC)
 - Foster Parents
 - Special Educators
 - Domestic Violence Shelter
 - Diagnostic Unit (DU)
 - Juvenile Justice facilities
 - Other congregate care settings

START Components

- Change Readiness
 - Present Discomfort
 - Internalization of Responsibility
 - Efficacy
 - Emotional Security
 - Preferred Alternative Future
- PTSD theoretical and diagnostic information
 - Trauma Questionnaire for Adolescents [Benamati, 2002]

START Components

- Attachment theory
 - Real Life Heroes [Kagan, 2004]
- Safe Environment
 - People, Places, Policies
 - Safety: Physical, Emotional, Moral [Bloom]

START Components

- Recognizing Trauma Reactivity – congregate perspective
- Responding to Individual and Group Reactivity
 - R.E.C.O.V.E.R.
 - Reduce the trauma stimulus
 - Explore fears and feelings
 - Connect feelings to maladaptive behavior
 - Offer alternatives
 - Validate choices
 - Evaluate level of stress
 - Return to routine

START Components

- Focus on and train for: **Competence** and **Confidence** of Direct Care Staff
 - Exercises
 - Change Readiness
 - Carlos and David
 - Contra factual Thinking
 - Benefit Finding/Benefit Reminding
 - Trauma Questionnaire
 - Affect Dysregulation
 - RECOVER
 - I-Statements and Reflective Listening

START Components

- Homework
 - Observe and document trauma reactivity in children
 - Safe Environment interviews of clients
- Report Backs
- Plan for Change – by unit (not individuals)
- Follow-up Consultation

START Components

- Organizational Culture Change
 - Train Units not Individuals
 - Tied to Agency Mission
- Embed Changes
 - Performance Evaluations
 - Direct Care Worker documentation
 - Supervision
 - Clinical Connection
 - Training

Day 1 Objectives:
Participants will be able to:

- discuss the connection of traumatic stressors to mental, psychological, and social problems of children
- reflect on their personal reaction to proposed changes in the treatment of traumatized children and engage in efforts to alleviate their possible resistance in light of the concept of change readiness

Day 1 Objectives

- state the three primary categories of PTSD symptoms as listed in the DSM-IV and give examples of each
- recognize and articulate characteristics of traumatic stress as demonstrated with case study activities
- describe an environment safe for victims of traumatic stress disorders and demonstrate understanding of the parameters by applying them in their regular work environment

Day 2 Objectives

Participants will be able to:

- use a chosen instrument to further understand and possibly assess for traumatic stress reactions in the residential population
- discuss the import of affect regulation and the role of childcare workers in helping children order and appropriately utilize emotional cues
- explain the impact of trauma on thinking processes, particularly the significance of counterfactual thinking

Day 3 Objectives

Participants will be able to:

- use relaxation to help a child suffering from traumatic stress
- discuss the steps of the R.E.C.O.V.E.R. counseling technique and demonstrate the use of the technique through role-play activity
- describe at least two (2) changes in agency policy, procedure, and philosophy that reflect an increased awareness of the needs of traumatized children

“Hurt people hurt people.”
-Sandra Bloom, MD

“Hurt People Can’t Help People”
Sanctuary Corollary

*“When parents place their children in our care,
they are counting on our competence and
praying for our compassion”*

-Raymond Schimmer, CEO
*Parsons Child and Family
Center*

Secure attachments act as a defense against trauma. (Our) role... is to help children modulate their arousal by attuned and well-timed provisions of playing, feeding, comforting, touching, looking, cleaning, and resting – in short, by teaching them skills that will gradually help them modulate their own arousal.



-van der Kolk (1996)

Lessons Learned(ing)

- If something is worth doing, it's worth doing poorly
- Tie training to agency mission
 - No, really do it
- Don't let best become the enemy of better
 - Find champions, don't wait for everyone
- A fish rots from the head [Farragher]
- Remember the non-Yiddish proverb

“A team is only as effective as its least effective member.”

- Not a Yiddish proverb

Locator information

Joseph Benamati, LMSW
Parsons Child and Family Center
60 Academy Road
Albany, NY 12208
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(518) 426-2655

www.parsonscenter.org/

Compendium of Trauma Assessments

http://www.parsonscenter.org/pages/training/pt_TraumaStudy.asp

Andrus Center for Learning & Innovation

Sanctuary Leadership Development Institute
at Andrus

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Web Resources

- National Child Traumatic Stress Network
http://www.ncetsnet.org/nccts/nav.do?pid=hom_main
- Sanctuary
<http://www.sanctuaryweb.com/>
- Andrus Children's Center
<http://www.andruschildren.org/ACLI.htm>
- Parson's Child and Family Center
<http://www.parsoncenter.org/pages/services/resCare.asp>

Feedback

What did you think?

What's next?

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Handouts and Evaluation

From the Internet:

<http://www.ocfs.state.ny.us/ohrd/>

From the Intranet:

<http://ocfs.state.nyenet/ohrd/distancelearning/satellite/>
