

Juvenile Justice Vision 20/20 Training Event
Trauma-Informed Care
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Presented by: Dr. Caelan Kuban

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Dr. Kuban believes trauma intervention is an essential part of a youth's treatment because it impacts the way a child views himself and the world around him, as well as impacts the child's emotions, behavior, learning and the ability to interact with others. In dealing with these youth, the question we should always ask is, "What happened to you," not "What's wrong with you?" She believes an individualized treatment approach is necessary.

There are several differences between grief and trauma. Grief involves a significant expression of sadness and does not disfigure one's identity. Many times grief is from a significant loss or regret: "I wish I would have...." A person may even dream of the person who dies or who was hurt, etc. The pain a person feels is related to the loss. Any anger associated with grief is usually not destructive in nature.

Trauma is defined as any experience that leaves a person feeling hopeless, helpless and/or fearing for his life, survival or safety. The general reaction to a trauma is terror with grief reactions also included. In the public and professional communities, grief and its effects are known while trauma is unknown, especially with regard to children. Trauma will distort a child's identity, and he/she will experience extreme guilt: "It was my fault." The pain involved in trauma is related to tremendous terror and a sense of powerlessness, fear and loss of safety. The anger experienced is assaultive, aggressive or violent, even if the trauma was not assaultive in nature.

It is important to remember that it is a person's perception of their experience, not ours, that makes something traumatic. Divorce may be more traumatizing than suicide or incarceration of a parent. We don't need to know as much about the facts as about the child's perception of how it happened.

Dr. Kuban said the child knows the events in his mind, but the hard part is finding words to describe it to someone else. We are quick to assume we know what the child went through. We have to be "curious" about their experience because that's the only way we will know what it was like. What may be the worst part in a trauma for one child may not be that way for another. Each situation is unique.

A child can experience trauma by being exposed to it in several different ways. We should be aware of the family dynamics – what else is going on in the child's family.

Trauma exposure can involve:

1. Surviving victim (abuse, neglect, car accident)
2. Personal Witness - fire, police, domestic violence
3. Related to (peer, sibling) – chronically ill sibling or one that committed suicide

4. Listening to details of traumas – therapists, media exposure, video games

When a child has a sibling that is chronically ill, that puts stress on others in the family. The child may be overly concerned that his sibling will die, he may not be getting enough attention as a result of the care given to the sibling by his parents, or he can't have friends over and experience a "normal" life as a result of the ill sibling.

The DSM 5 Manual has several changes with regard to Post Traumatic Stress Disorder. Two new additions include: (1) a pre-school subtype for children six and under: Posttraumatic Stress Disorder in Preschool Children; and (2) PTSD with prominent dissociative symptoms (feeling detached from one's own mind or body – experiences that seem unreal or dreamlike). Another addition under PTSD was a category labeled "Negative Cognitions and Mood".

A 2009 proposed Diagnostic Category for DSM 5 was Developmental Trauma Disorder (Dr. Bessel van der Kolk and Dr. Robert Pynoos); although this was proposed twice, it was not included. Rather than having multiple diagnoses, the child may be experiencing many symptoms from traumas. A child who keeps washing his hands or locking doors may be misdiagnosed OCD when he is actually showing symptoms of traumas that may have occurred in early childhood; i.e., feeling unclean from sexual abuse or fear of being molested when sleeping.

Trauma is a precursor for many, many disorders. Rather than labeling a child with a diagnosis and prescribing medicine, Dr. Kuban said we need to see what is at the root of the symptomology: the trauma. Medication is trying to treat something that isn't true.

The Adverse Childhood Experience (ACE) Study is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being, involving more than 17,000 participants. The findings suggest that certain experiences are major risk factors for the leading cause of illness and death, as well as poor quality of life in the U.S.

There is a direct link between youth and delinquency/adjudication. Youth that are part of the juvenile justice population have significantly higher incidences of trauma, with over 90 percent of juvenile detainees reporting at least one traumatic event. The occurrence of multiple complex traumas is frequently reported among incarcerated youth.

According to the Michigan Juvenile Justice Collaborative, child abuse and neglect increases the risk of arrest as a juvenile by 55 percent and increases the risk of being arrested for a violent crime as a juvenile by 96 percent. A significant relationship between maltreatment and delinquency was found in data collection from 1,200 youth across the nation.

Dr. Kuban cited several studies linking trauma and delinquency:

1. Interpersonal violence exposure increases risk for PTSD symptoms, depression, binge drinking and delinquency (Cisler et al, 2012).
2. Multiple trauma exposure increased the risk for violence perpetration (Duke et al, 2010)
3. Family conflict and school isolation increased vulnerability to delinquency (Ford et al 2006).

There is a major difference between acute stress versus posttraumatic stress. Acute stress is a normal response or reaction to stress or trauma, but the body returns to normal after four to six weeks. In posttraumatic stress, there is an exaggerated and prolonged stress response beyond four to six weeks which can even last years. There is a deregulation of stress chemistry so the stress hormones don't come back down to normalcy; and there is an increased activation of the sympathetic nervous system (heart rate, startle response, fight response). Many times the resting heart rate for people with PTS is in the 100s.

PTS affects the brain. This can be explained to kids to give them knowledge to understand and make better decisions. Trauma is a sensory experience because of what happens to the brain and memory during trauma. Dr. Kuban believes using sensory interventions to help relieve the pain and terror associated with the trauma because there are "no words", only images and sensory images of the trauma.

The right brain (sensory brain, visual, auditory, 5 senses) is fully developed at birth with the spinal cord and brain stem. The emotional regulation or affectation is the second function the right brain performs. The caregiver is responsible for this; the more we respond to the infant, the more the infant is able to trust and learns how to cope. The third function of the right brain is memory. Memory is linked to sensation and how we store them.

The left brain is the "thinking brain" which involves impulse control, higher level of thinking, language, problem solving, and reasoning. This begins to develop after birth, but is not fully developed until the end of adolescence (or some estimate around age 23). One traumatic event in anyone's life, especially a child's, can alter both the structure and the chemistry of the brain.

If a child experiences trauma, then stress hormones are released and there is an interference with the brain's coping mechanisms. If there is a deregulation in the right brain, then the situation is worsened since there is no emotional regulation. A child will smoke pot because they are doing something to bring down the "arousal" so they can use the left side of their brain.

The first step in trauma-informed care is to lower the arousal first so the stress hormones will go back into balance and the right and left brain will work together. Then any therapy that uses cognition will work better because you can't modify behavior until the child can activate the left part of the brain and think cognitively. This is done by deep breathing which lowers the sympathetic nervous system and engages the para-sympathetic nervous system.

Empathy is necessary; telling the child you are happy to see them, you are glad they are there; keep giving them an element of trust. Speak in a calm voice with eye contact; use stress balls to squeeze or let them bounce tennis balls. Let the child know it is "normal" for them to be stressful in your office; let them know they aren't "crazy".

How do we help? Children have a desire to share details of the trauma when given appropriate opportunities. We need to see how the child sees himself and the world around him to know how much the trauma has impacted him. The child needs to share the details and give us a visual representation of what their experience was like.

Some of the steps with trauma-informed care are:

1. Address the sensory first
2. Reduce arousal so the stress hormones come back into balance
3. Do this on a sensory level, not cognitive level
4. Is it trauma specific or are there “themes” of trauma – safety or lack thereof; worry; hurt; fear; anger/revenge; victim; loss of future orientation/hopelessness/helplessness
5. Then work on cognitive/problem-solving and reframing

Ask some questions: When the hurt is in your body, what does it feel like? How can you describe your hurt so much so I know what it feels like? If it was a color, what would it look like, or a song, what would it sound like? If hurt could talk, what would it say? Does someone or something make it better? How do you know when you’re starting to get angry? If a child can’t articulate his feelings, then have him draw them: draw me a picture that shows me what your worry looks like. What time of day was it? What did you see? What else is going on? What was the worst part?

The next step is cognitive reframing. This consists of changing the way people see things and trying to find alternative ways of viewing ideas, events and situations. “Wow, despite all that has happened, you keep moving forward, doing and learning new things.” Rape example: “There isn’t anything else I could have done.”

Remember that parts of the brain can’t be changed unless they are activated. Sufficient repetition is the only way change will occur and it will become second nature to the child. The process is long and requires patience. Remember that moment to moment daily interactions between the child and staff are what shape the child’s ability to manage and control emotions and to develop healthy relationships.