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Innovations and Trends in Organizational Responses to Trauma

Introduction

- Recovery following traumatic loss
- Child and adolescent responses to community exposure to violence
- Community-based mental health delivery

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What is trauma?

- **Traumas are emotionally overwhelming, highly upsetting events that may involve actual or threatened death, serious injury, or sexual violence**

- [[1] American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.]

Modern History Understanding of Trauma

Herman Oppenheim said, 'functional problems are produced by molecular changes in the central nervous system, any suggestion that these difficulties could have an origin in an individual's perceptions of a traumatic event is incorrect' (Oppenheim 1889)

Some varieties of post-traumatic illness

Accident neurosis	Post-traumatic stress syndrome
Accident victim syndrome	Post-Vietnam syndrome
Battleshock	Profit neurosis
Combat fatigue	Railway spine
Combat stress neurosis	Shell shock
Compensationitis	Soldier's heart
Da Costa's syndrome	Traumatic neurasthenia
Erichsen's disease	Vertebral neurosis
Litigation neurosis	War neurosis
Nostalgia	Whiplash neurosis

Source: O'Brien, 1998.[2]

Post-Traumatic Stress Disorder (PTSD)

- World War I and II, Shell Shock
- Charles Myers, ‘my term shell shock is misleading . . . the true cause of the soldier’s problems is the shock and horror of war’ (1940).
- 1980, American Psychological Association introduces Post-Traumatic Stress Disorder in the 3rd Edition of the Diagnostic Statistical Manual

DSM-V Diagnostic Criteria

Posttraumatic Stress Disorder for Children 6 Years and Younger

A. In children 6 years and younger, exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
   1. Directly experiencing the traumatic event(s).
   2. Witnessing, in person, the event(s) as it occurred to others, especially primary caregivers.
      Note: Witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures.
   3. Learning that the traumatic event(s) occurred to a parent or caregiving figure.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
   1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
      Note: Spontaneous and intrusive memories may not necessarily appear distressing and may be expressed as play reenactment.
   2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
      Note: It may not be possible to ascertain that the frightening content is related to the traumatic event.
   3. Dissociative reactions (e.g., flashbacks) in which the child feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Such trauma-specific reenactment may occur in play.
   4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
   5. Marked physiological reactions to reminders of the traumatic event(s).

C. One (or more) of the following symptoms, representing either persistent avoidance of stimuli associated with the traumatic event(s) or negative alterations in cognitions and mood associated with the traumatic events(s), must be present, beginning after the event(s) or worsening after the event(s):

   Persistent Avoidance of Stimuli
   1. Avoidance of or efforts to avoid activities, places, or physical reminders that arouse recollections of the traumatic event(s).
   2. Avoidance of or efforts to avoid people, conversations, or interpersonal situations that arouse recollections of the traumatic event(s).

   Negative Alterations in Cognitions
   3. Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame, confusion).
   4. Markedly diminished interest or participation in significant activities, including constriction of play.
   5. Socially withdrawn behavior.
   6. Persistent reduction in expression of positive emotions.

D. Alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects (including extreme temper tantrums).
   2. Hypervigilance.
   3. Exaggerated startle response.
   4. Problems with concentration.
   5. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

E. The duration of the disturbance is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in relationships with parents, siblings, peers, or other caregivers or with school behavior.

G. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and the individual experiences persistent or recurrent symptoms of either of the following:
   1. **Depersonalization:** Persistent or recurrent experiences or feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
   2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant or distorted).

   Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts) or another medical condition (e.g. complex partial seizures).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Complexities with the Diagnosis

What if there is no “post”?

Complex trauma

(1) repetitive, prolonged, or cumulative

(2) most often interpersonal, involving direct harm, exploitation, and maltreatment including neglect/abandonment/antipathy by primary caregivers or other ostensibly responsible adults, and

(3) often occur at developmentally vulnerable times in the victim's life, especially in early childhood or adolescence, but can also occur later in life and in conditions of vulnerability associated with disability/ disempowerment/dependency/age /infirmity, and so on.

A Modern Interpretation of PTSD

- https://www.youtube.com/watch?v=9MhAAs8LDOI

Adverse Childhood Experiences

Adverse Childhood Experiences

- The ACE Study is ongoing collaborative research between the Centers for Disease Control and Prevention in Atlanta, GA, and Kaiser Permanente in San Diego, CA.
- Data from over 17k participants reveals staggering proof of the health, social, and economic risks that result from childhood trauma

What is measures:

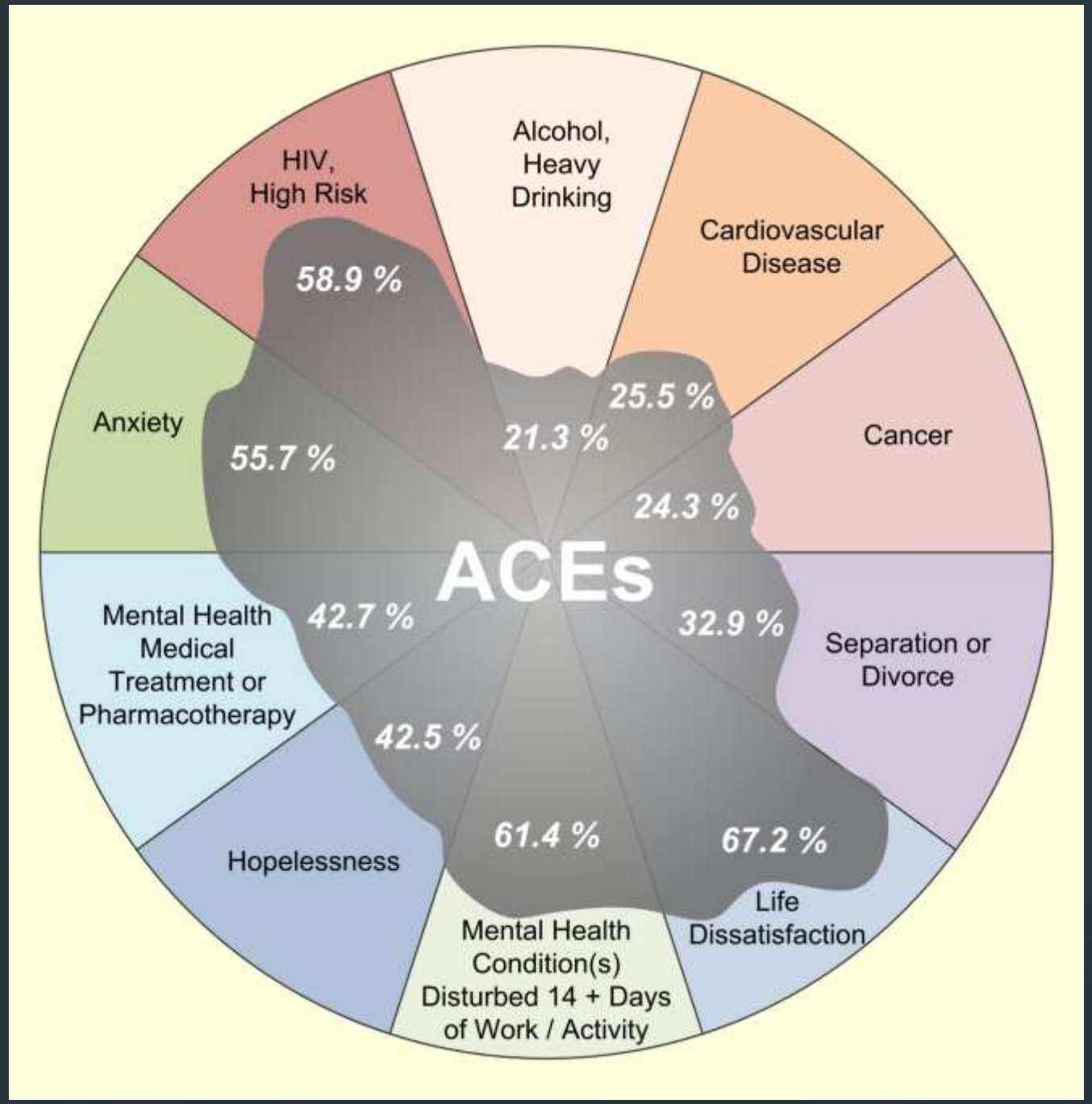
A HISTORY OF THE FOLLOWING BY AGE 18:

- Physical, Emotional, or Sexual Abuse
- Physical or Emotional Neglect
- Mental Illness
- Prison
- Domestic Violence
- Divorce or Parental Loss
- Substance Abuse

POPULATION ATTRIBUTABLE RISK

A large portion of many health, safety and prosperity conditions is attributable to Adverse Childhood Experience.

ACE reduction reliably predicts a decrease in all of these conditions simultaneously.



Cost-Effectiveness of Prevention

- **According to the CDC,** just one year of confirmed cases of child maltreatment **costs $124 billion** over the lifetime of the traumatized children. The researchers based their calculations on only confirmed cases of physical, sexual and verbal abuse and neglect, which child maltreatment experts say is a small percentage of what actually occurs.
- **The breakdown per child is**:
  - $32,648 in childhood health care costs
  - $10,530 in adult medical costs
  - $144,360 in productivity losses
  - $7,728 in child welfare costs
  - $6,747 in criminal justice costs
  - $7,999 in special education costs

An Organizational Response: Trauma-Informed Care

- **Safety**
- **Trustworthiness and transparency**
- **Peer support and mutual self-help**
- **Collaboration and mutuality**
- **Empowerment, voice, and choice**
- **Cultural, historical, and gender issues**

A Critique of Trauma-Informed Care

- 1) Overly individualistic: “Current formulations of trauma informed care presumes that the trauma is an individual experience, rather than a collective one. ”
- 2) Surface-level interventions: “Trauma informed care requires that we treat trauma in people but provides very little insight into how we might address the root causes of trauma in neighborhoods, families, and schools”
- 3) Deficit-based: “The term trauma informed care runs the risk of focusing on the treatment of pathology (trauma), rather than fostering the possibility (well-being)”

Healing-centered engagement

A healing centered approach to addressing trauma requires a different question that moves beyond “what happened to you” to “what’s right with you” and views those exposed to trauma as agents in the creation of their own well-being rather than victims of traumatic events.

Principles of Healing Centered Engagement

- Healing-centered engagement is explicitly political, rather than clinical
- Healing-centered engagement is culturally grounded and views healing as the restoration of identity
- Healing-centered engagement is asset driven and focuses on well-being we want, rather than symptoms we want to suppress
- Healing-centered engagement supports adult providers with their own healing

Lisa Daniels

https://soundcloud.com/2sidesofjustice/sets/lisa

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