**Re-Traumatization/Re-Enacts Past Trauma/Re-Triggers Symptoms**

| Early Childhood Trauma | Common Institutional Practices | Trauma Informed Care Approaches |
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| Unseen and Unheard* Don’t talk about it.
* Priority was to protect family/reputation.
* Hopelessness
* Trauma not seen
 | * Misdiagnosed
* Denial, "paranoid", "chronic"
* Silencing
* Diagnosis given
* No word in the treatment process and/or family involvement
 | * Youth satisfaction surveys
* Staff who listen and are calm
* Safe place to do trauma work – share anger and emotions safely, memory work, and recovery focus.
* Ask “What is your Story” (not a diagnosis)
* What happened to you vs. what is wrong with you?
* Youth input/council
* Youth participation in case planning and decision making
 |
| Trapped* Unable to escape childhood abuse
* Dependent as child on family
 | * Abused in placement/facility
* Handcuffed/retrained/shackled/locked up
* Kept dependent
 | * Design spaces for safety, privacy, and regulation.
* Safety planning
 |
| Boundaries* Violated
* Exposed, no privacy
 | * No privacy from others/staff
* No boundaries
* Violation of confidentiality
 | * Staff who take care of themselves
* Staff compassion fatigue training and on-going support
* Boundary policy – investigate alleged boundary violation(s)
* Staff training on empathy, boundaries, and ethics
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| Isolated* "Why just me?"
* "I thought I was the only one"
* "Alone"
 | * Separated from family/community in facility
* Seclusion practices
* Not given medication/therapy in higher level of care (detention/jail).
 | * Recovery happens in relationships/develop connections
* Peer support
 |
| Disempowerment and Disconnection* Childhood sexual abuse is disempowerment and disconnection
 | * Rigid crisis protocols based on depression model
* Unilateral decision making
* Cookie cutter treatment based on diagnosis
 | * Skill building
* Shared decision making
* Empowerment/ voice and choice
* Recognizing triggers and warning signs
* Trauma specific screening, timely referral, interventions, and recovery
* Aligning goals with treatment and recovery goals
 |
| Blamed and Shamed* “It’s not what is presenting now”.
* “I had this feeling I was bad….a bad seed”.
* “I was difficult to handle”.
* “I am bad”.
* Blamed, spanked, confined to room for anger, screams, cries, tantrums.
 | * Don’t deal with trauma because it’s pathologized and labeled as a diagnosis.
* Treated as worthless/lack of respect
* “Non-compliant”, “treatment-resistant”, “manipulative”, “frequent flyer”.
* Rage, terror screams, cries, controlled and punished by medication, restraint, loss of privileges and seclusion. “Fix the problem”.
 | * Healing relationships are supportive and understanding
* Rage is about fear and lack of power/not about controlling or violence with more violence
* Safe and healthy place to release anger
* Staff staying regulated, calm, and understanding
* While not condoning inappropriate behaviors, avoid blaming youth and treating him/her as a bad person
 |
| Powerless* Perpetrator had absolute power/control
* Helpless
 | * Does not demonstrate respect for client’s wishes.
* Replicates power imbalance of original trauma.
* Staff have absolute power/control over youth.
* Staff hierarchy (in control of youth).
* “Us and them”.
* Protocols/rules that are not trauma-informed.
 | * Youth feedback collected/satisfaction surveys
* Collaboration and mutuality
* Youth council
* Youth rights and responsibilities
* Full partners in the treatment and recovery process
* Non-traditional approaches – learning positive coping skills, grounding techniques, yoga, art therapy, mindfulness, self-soothing kits, meditation, music, drumming
* Regulating affect
 |
| Unprotected* Defenseless against perpetrator abuse.
* No safe place.
* Vulnerable.
 | * Youth may experience staff abuse, name-calling.
* Language of oppression replicates abuse
* Insensitivity to gender issues.
 | * Policy safeguards written to protect youth (Trauma Survivor Rights)?
* Confidentiality respected
* Wellness Recovery Action Plans (WRAP)
* Safety and crisis planning with youth/family input
* Gender appropriate boundaries
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| Threatened* Constant threat of being abused.
* Fear, “threats from past are still present”.
* Expression of any intense feeling is punished.
 | * Threat of going to court, more sanctions, going to prison
* Viewed as dangerous and disruptive.
* Unrealistic expectations.
* Being set up for failure: not understanding impacts of trauma.
 | * Trustworthiness and transparency
* De-escalation policies and training that is trauma informed
* Identification of triggers
* Staff training on triggers and re-traumatization
* Use of art therapy and healthy ways to vent emotions
* On-going suicide risk assessments
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| Discredited* As a child, reports of abuse unheard, minimized, or silenced.
 | * Reports of child trauma not believed, not discussed, unheard, ignored.
* Trauma symptoms are misinterpreted.
* Misdiagnosed.
* Being treated as if youth aren’t intelligent.
* “It’s time you got over it…”
 | * Trauma screening and trauma specific referral and interventions
* Use of ACE Survey, Resilience Survey, 40 Developmental Assets
* Focus on the person, not the diagnosis
* Symptoms are adaptations to trauma informed care events
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| Betrayed* Childhood trauma led to lack of trust and no one to depend on.
 | * Staff relationships disrupted.
* Lack of continuity of care.
* Lack of trust between youth and staff.
 | * Develop trust and relationships
* Will seek to do no further harm
 |
| Worthlessness, Shame, and Inferiority* “I have no self-esteem”.
 | * Environmental insensitivities such as:
* Keeping clients waiting for long periods of time.
* Separate bathrooms for staff and clients.
* Humiliating/lengthy intake process of telling story over and over to several different staff.
* Lack of secure, private sleeping space.
* Lack of trauma screening and referral.
 | * Strength based
* Peer support
* Focus on resiliency
* From what’s wrong with you to what has happened to you?
* Empathy and understanding in the way questions are asked. Establish mutual trust
* Trauma screening and referral
 |
| Organizationally |  | * Utilize the Trauma Informed Care Organizational Assessment annually
* Complete trauma informed care environmental scan annually to create safe, predictable environmental conditions to promote healing and recovery
* On-going staff and supervisor trauma training including Compassion Fatigue
* Administrative support for trauma informed care
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*Taken in part from Ann Jennings (*[*www.theannainstitute.org*](http://www.theannainstitute.org)*)*