Steele, William.
Trauma-informed practices with children and adolescents / William Steele, Cathy A. Malchiodi.

p. ; cm.
Includes bibliographical references and index.
Summary: “Trauma-Informed Practices with Children and Adolescents is a sourcebook of practical approaches to working with children and adolescents that synthesizes research from leading trauma specialists and translates it into easy-to-implement techniques. The approaches laid out address the sensory and somatic experiences of trauma within structured formats that meet the “best practices” criteria for trauma informed care: safety, self-regulation, trauma integration, healthy relationships, and healthy environments. Each chapter contains short excerpts, case examples, and commentary relevant to the chapter topic from recognized leaders in the field of trauma intervention with children and adolescents.
In addition to this, readers will find chapters filled with easily applied activities, methods, and approaches to assessment, self-regulation, trauma integration, and resilience-building. The book’s structured yet comprehensive approach provides professionals with the resources they need to help trauma victims not just survive but thrive and move from victim thinking to survivor thinking using the current best practices in the field”--Provided by publisher.
Contents

Foreword ........................................................................................................................................ ix
Acknowledgments ......................................................................................................................... xiii
Introduction ..................................................................................................................................... xv
About the Authors .......................................................................................................................... xxiii
About the Contributors ................................................................................................................... xxvii

1  What Is Trauma-Informed Practice? ................................................................. 1
2  Trauma-Informed Assessment ............................................................................. 23
3  Sensory-Based, Trauma-Informed Assessment .................................................. 49
4  Establishing Safety Through Self-Regulation .................................................... 75
5  Creating and Sustaining Trauma-Informed Environments ............................... 99
6  Trauma-Informed Relationships ....................................................................... 135
7  Supporting Resilience and Posttraumatic Growth ......................................... 169
8  Trauma Integration ................................................................................................. 197
References ............................................................................................................................... 217
Index ......................................................................................................................................... 235

Chapter 1

What Is Trauma-Informed Practice?

Each day children and adolescents are exposed to traumatic events including abuse, domestic violence, accidents, witness to homicide, divorce and separation, loss, disasters, and war. They may encounter these events from early childhood through teenage years; some experience multiple traumas or live in situations that include chronic neglect, abandonment, and abuse. Given the complexity and variability in the severity of young people’s exposure and responses to trauma, it is not surprising that the identification of effective treatment has only recently materialized.

This chapter reviews the previous and current theories about trauma intervention with children and adolescents and how these approaches have enhanced understanding of trauma-informed approaches. It also presents contemporary findings in neuroscience, psychology, and medicine that have influenced trauma intervention, including cognitive-behavioral, somatic, sensory integration, and expressive arts therapies. Finally, a comprehensive definition of trauma-informed practice is presented with an emphasis on the key factors necessary in developing effective assessment, environments, relationships, and treatment.

Traumatic Stress Reactions in Children and Adolescents

Over previous decades, researchers have conducted extensive investigations examining trauma reactions in children and adolescents. The recognition of
societal, domestic, and interpersonal violence against children during the mid-1980s precipitated significant research on its impact and revealed strong evidence that “acute posttraumatic stress symptoms result from violent life threat, and that severity is related to the extent of exposure to the threat or witnessing of injury or death” (Pynoos, Nader, Arroyo et al., 1987 p. 1057). In the 1990s, numerous authors described trauma reactions in children induced by physical and sexual abuse, (Famularo, Kinscherff, & Fenton, 1992), witness to parental homicide and violence (Trickett & Putnam, 1993; Deblinger, Lippman, & Steer, 1996), and exposure to living in violent communities (Terr, 1990; Saigh & Bremner, 1999; Garbarino, 1992; Wallen, 1993). During the same time, trauma specialists realized that trauma and PTSD were not only specific to exposure to violence, but also to other traumatic events such as natural disasters, for example, fires (McFarlane, Policansky, & Irwin, 1987; March Jackson, Costanzo, & Terry, 1993), hurricanes (Lonigan, Shannon, Finch, Daugherty, & Taylor, 1991; Vernberg, LaGreca, Silverman, & Prinstein, 1996), boating incidents (Yule, 1992), burns and other serious accidents, and medical procedures such as bone marrow transplants (Stubner, Nader, Yasuda, Pynoos, & Cohen, 1991). Living with a terminally ill adult or sibling, drowning, house fires, car fatalities, living with substance-abusing parents and divorce were also identified as events that preceded the onset of PTSD in children (Raider, Steele, & Santiago, 1999).

While PTSD was recognized as a diagnostic category in 1984, it was not until 1994 that children were included in this category by the American Psychiatric Association (APA, 1994). The description of the disorder, however, was not conclusive or comprehensive in its coverage of childhood trauma. The category failed to capture what Herman (1992) and van der Kolk, Roth, Pelcovitz, and Mandel (1993) described as the outcomes of those who experienced chronic, multiple, long-standing, repeated events and atrocities of human design and intent. In 1992 Herman wrote, “while the victim of a single acute trauma may feel after the incident that she is not herself, the victim of chronic trauma may feel herself to be changed irrevocably or she may lose the sense that she has any self at all” (p. 86).

The Adverse Child Experiences (ACE) supported by the Centers for Disease Control (CDC) is advancing understanding of the relationship between multiple childhood traumatic events and adverse outcomes later in life. The initial phase of the ACE study began in 1995 with more than 17,000 participants whose exposure to childhood maltreatment and family dysfunction are being tracked along with current health status and behaviors. Almost two-thirds of participants reported at least one adverse childhood
experience, and more than one of five reported three or more ACEs. The short- and long-term outcomes of these childhood exposures include a multitude of health and social problems including heart and liver disease, alcoholism, drug abuse, fetal death, and interpersonal violence (CDC, 2011). The ACE study underscores that childhood trauma does not only impact psychosocial outcome, but also physical well-being and overall health (Corso et al., 2008; Chapman et al., 2007).

**Neuroscience: Enhancing Understanding of Trauma Memory and Reactions**

During the 1990s and early 21st century, neuroscience research enhanced our understanding of the effects of trauma on the mind and body. In *Traumatic Stress*, van der Kolk, McFarlane, and Weisaeth (1996) observe that when a terrifying incident such as trauma is experienced and does not fit into a contextual memory, a new memory or dissociation is established and memories are “stored initially as sensory fragments that have no linguistic components” and furthermore, “that intrusive sensations, even after the construction of a narrative, contradict the notion that learning to put the traumatic experience into words will reliably abolish the occurrence of flashbacks (and other reactions)” (p. 289). Michaesu and Baeltig (1996) also explain that memories of trauma are not stored “explicitly” (cognitively) or within a contextual framework, but “implicitly” in iconic and sensory forms. In essence, trauma memories are experienced and remembered through images and sensations. Terr (1994) reports that memories of traumatized individuals are far more emotional and perceptual in content than declarative components. Steele (2003) also notes that when memory cannot be linked linguistically in a contextual framework, it remains at a symbolic (iconic) level and there are no words to describe it, only sensations and images. Before traumatic memory can be encoded, expressed through language, and successfully integrated, it must be retrieved and implicitly externalized in its symbolic (iconic) sensory forms (p. 142). The trauma experience, therefore, is more easily communicated through imagery and activities associated with the sensory experiences of those incidents than through cognitive processes (Malchiodi, 2001, 2008).

Other authors underscore the mind–body connection in trauma reactions and PTSD. Levine (1997) suggests that trauma is experienced primarily in the
nervous system and that it is a physiological phenomenon as much as a purely psychological one. He indicates that when children’s physiological survival systems are activated by threat, the excess energy used to defend oneself must be expended. If that energy is not fully discharged and metabolized, it does not simply disappear. Instead it remains as a kind of highly charged body memory creating the potential for repeated traumatic symptoms.

In *The Body Remembers*, Rothschild (2000) observes that the sensations experienced at the time of trauma are contained in the body rather than stored solely as cognitive memories; these sensations are activated when similar events are experienced after the actual trauma passes. Bessel van der Kolk (2006) echoes Rothschild’s observations, saying, “For therapy to be effective it might be useful to focus on the patient’s physical self-experience and increase their self-awareness, rather than focusing exclusively on the meaning that people make of their experience …” (p. 13).

Perry (2006) provides a neurosequential model of therapeutics (NMT), a developmentally informed, biologically respectful approach to working with at-risk children. NMT is not a specific therapeutic technique or intervention; it is a way to organize the children’s history and current functioning to optimally inform the therapeutic process. It integrates several core principles of neurodevelopment and traumatology into a comprehensive approach to the child, family, and the community. The NMT process helps match the nature and timing of specific therapeutic techniques to the developmental stage of the child, and to the brain region and neural networks that are likely mediating the neuropsychiatric problems. This approach structures assessment of the child, articulates primary problems, identifies key strengths, and applies educational and therapeutic interventions that will help family, educators, therapists, and related professionals best meet the needs of the child (Perry & Hambrick, 2008).

**Developmental Trauma**

NMT reflects the recent recognition of the importance of developmental factors in the evaluation and treatment of trauma in children and adolescents. Many practitioners today appreciate that the current PTSD category does not reflect the actual experiences of traumatized children. It also does not integrate developmental factors that contribute to the complexity of exposure to trauma during childhood.
What Is Trauma-Informed Practice?

The Roots of Trauma

Peter Levine and Maggie Kline

A child's brain/body develops and is shaped through the experiences s/he has, both traumatic and reparative. Fortunately, because of the brain's plasticity and the biological imperative to move toward self-regulation, with a little understanding and skill of how to engage a child's instinctual resources, clinicians (and parents) can help transform symptoms of fear to robust self-confidence and resilience.

A method called Somatic Experiencing® (SE) is currently being employed successfully in the prevention and healing of trauma. The premise of SE is that trauma is a fact of life; but so is resilience. Trauma can result from events that are clearly extraordinary, such as violence and molestation, but it can also result from everyday “ordinary” events. In fact, common occurrences such as accidents, falls, invasive medical procedures, and divorce can cause children to withdraw, lose confidence, or develop anxiety and phobias. Traumatized children may also display behavioral problems including aggression, hyperactivity, and as they grow older, addictions of various sorts and dysfunctional relationships.

In order to help children feel secure and balanced, it is necessary to recognize the underlying roots of trauma, how the trauma response is held in the body as implicit/procedural memory, and how it disturbs the child's self-regulatory capacities. In other words trauma is a physiological phenomenon, rather than a purely psychological one. As such, psychologists, psychiatrists, and other helping professionals need to understand the core mechanisms of how to stabilize the body’s reactions to traumatic stress on the physical level in order to help children and teens regulate their sensations and emotions.

Trauma is Not Only in the Event

Trauma happens when an intense experience stuns a child like a bolt out of the blue; it overwhelms the child, leaving him or her altered and disconnected from his body, mind, and spirit. Coping mechanisms are undermined and he feels utterly helpless. It is as if his legs were knocked out from under him. Trauma can also be the result of ongoing...
fear and nervous tension. Long-term stress responses wear down a child, causing an erosion of health, vitality, and confidence.

While the magnitude of the stressor is clearly an important factor, it does not define trauma. Here the child’s capacity for resilience is paramount. In addition, trauma resides not in the event itself; but rather its effect in the nervous system. The basis of single-event trauma (as contrasted to ongoing neglect and abuse) is primarily physiological rather than psychological. What we mean by “physiological” is that there is no time to think when facing a threat; therefore, our primary responses are instinctual. Our brain’s main function is survival! We are wired for it. At the root of a traumatic reaction is our 500-million-year heritage—a heritage that resides in the oldest and deepest structures of the brain.

THE RECIPE FOR TRAUMA

When these primitive parts of the brain perceive danger, they automatically activate an extraordinary amount of energy—like the adrenaline rush that allows a mother to lift an auto to pull her trapped child to safety. This fathomless survival energy that we all share elicits a pounding heart along with more than 20 other physiological responses designed to prepare us to defend and protect ourselves. These rapid involuntary shifts include the redirection of blood flow away from the digestive and skin organs and into the large motor muscles of flight, along with rapid respiration and a decrease in the normal output of saliva. Pupils dilate to increase the ability of the eyes to take in more information. Blood-clotting ability increases, while verbal ability decreases. Muscles become highly excited, stiffening in preparation for action with a vast expenditure of energy. Alternatively, when faced with inescapable threat or prolonged stress, certain muscles collapse in fear as the body shuts down in an overwhelmed frozen state as the last-ditch default response.

While the body may look inert in this state of freeze/collapse, those physiological mechanisms that prepare the body to escape may still be prepared for “full charge.” Muscles that were poised for action at the time of threat are thrown into a state of immobility or shock. When in shock, the skin is pale and the eyes vacant, the pupils may be small pinpoints. Breathing is shallow and rapid, or just shallow. The sense of time is distorted. However, underlying this situation of helplessness is
an enormous vital energy. This potential energy lies in wait to complete whatever action had been initiated. In addition, young children (this can happen with older children, too, especially girls) tend to bypass active responses, becoming motionless instead. Later, even though the danger is over, a simple reminder can send the exact same alarm signals racing once again through the body until it becomes hyperaroused and/or shuts down. When this happens we may see the child becoming agitated, sullen, depressed, whiny, clingy, and withdrawn.

Whether a youngster is still fully charged or has shut down and resigned, the guidance of a therapist or other adult is imperative to alleviate their traumatic stress response and to build up their resilience and confidence. Furthermore, younger children generally protect themselves not by running away, but by running toward (and attaching to) the protective adult. Hence, to help children resolve a trauma, there must be a safe adult to support them. The adult who has the skills of emotional first aid can help them literally “shake things off” and breathe freely again as their nervous system “resets.”

How does the outpouring of survival energy and multiple changes in physiology affect children and teens over time? The answer to this question is an important one in understanding the consequences of trauma. This depends on what happens during and after the threat. The catch is that to avoid being traumatized, the excess energy mobilized to defend oneself must be used up. When the activation is not fully discharged and metabolized, it does not simply go away; instead it remains as a kind of highly charged “body memory” creating the potential for repeated traumatic symptoms. This type of imprint is not primarily conscious but is registered unconsciously as implicit procedural (i.e., motoric) memory. Children who are guided with consistent, patient support to release this highly charged state can easily return to healthy, flexible functioning. When a child is overwhelmed, whether from a traumatic event or cumulative stress, his or her self-protective reflexes and fight-or-flight mechanisms become unavailable. With physical shutdown, children develop feelings of helplessness and hopelessness. The recipe for recovery lies in restoring these bodily resources, which lead to self-regulation.

If these same children had been cheetah cubs, they wouldn’t need our help. After withstanding terrifying exposure to danger (such as from
The National Child Traumatic Stress Network (NCTSN) (2009) supports the inclusion of a new, more comprehensive PTSD category for children and adolescents called developmental trauma disorder (DTD). Van der Kolk, Pynoos et al. (2009) explain, “Whether or not they exhibit symptoms of PTSD, children who have developed in the context of ongoing danger, maltreatment, and inadequate care-giving systems are ill served by the current diagnostic system, as it frequently leads to no diagnosis, multiple unrelated diagnoses, an emphasis on behavioral control without recognition of interpersonal trauma and lack of safety in the etiology of symptoms, and a lack of attention to ameliorating the developmental disruptions that underlie the symptoms.” Traumatic events have their most pervasive and significant influence during the first 10 years of children’s lives, although the current PTSD category does not adequately describe these children’s behavior and symptoms. As a result, children may be given a wide range of co-morbid diagnoses that imply that symptoms occur independently from PTSD symptoms. Essentially, helping professionals may miss important opportunities for trauma-informed intervention if only co-morbid diagnoses are the focus and the impact of DTD is left unaddressed.

According to van der Kolk, Pynoos et al. (2009), DTD includes the following criteria:

- **Exposure.** There are multiple or chronic exposures to one or more forms of developmentally adverse interpersonal trauma (abandonment, betrayal, physical assaults, sexual assaults, threats to bodily integrity, coercive practices, emotional abuse, witnessing violence, and death) and subjective experience (rage, betrayal, fear, resignation, defeat, and shame).
What Is Trauma-Informed Practice?

Repeated Dysregulation. Trauma responses persistently include dysregulation in affective functioning; somatic functioning (motoric, medical, physiological); behavior (reenactment); cognition (confusion, dissociation, repetitive thoughts about trauma events); relationships (oppositional, mistrust, overly compliant); and self-attributions such as self-hate or blame.

Persistently Altered Attributions and Expectancies. These may include negative self-attribution, loss of expectation of safety or protection by others and social agencies, lack of belief in retribution or social justice, expectation of future victimization, and general distrust of caregivers.

Functional Impairment. Functional impairments may occur in any of the following areas: educational, familial or social relationships, vocational, and self-efficacy.

Trauma Versus Grief Reactions

Many practitioners confuse trauma and grief reactions in children and adolescents. In brief, grief is an emotional response that accompanies loss; when experiencing a trauma, there is often grieving about what is lost whether it is a significant person, possessions, home, or even the loss of innocence when betrayed by abuse or abandonment. Reactions to grief and trauma are different and it is important to distinguish these reactions in traumatized children and adolescents; for this purpose, Table 1.1 is provided to summarize the differences and underscore the common reactions found in those who are traumatized versus those who are grieving.

A Brief History of Trauma Intervention With Children and Adolescents

It was not that long ago when practitioners concurred that addressing traumatic events with children and adolescents was detrimental and even counterproductive to their emotional reparation and recovery. Several decades ago, children were not believed to be capable of even experiencing trauma symptoms. In fact, when 26 children were buried alive and survived the Chowschilla School Bus kidnapping in California in 1976, doctors pronounced the children to be in good physical condition.
and did not request any further mental health intervention. Fortunately, Lenore Terr, a psychiatrist, was invited to study the children some 5 months later. Terr evaluated children at different developmental stages and was the first to study children's trauma reactions over time. The Chowchilla findings described in *Too Scared to Cry* (1990) eventually

Table 1.1  **Grief Reactions Versus Trauma Reactions**

<table>
<thead>
<tr>
<th></th>
<th>GRIEF</th>
<th>TRAUMA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grief generally does not attack or “disfigure” our identity.</td>
<td>Trauma generally attacks, distorts, and “disfigures” our identity.</td>
<td></td>
</tr>
<tr>
<td>In grief, guilt says, “I wish I would or would not have …”</td>
<td>Trauma guilt says, “It was my fault. I could have prevented it. It should have been me.”</td>
<td></td>
</tr>
<tr>
<td>In grief, dreams tend to be of the person who died.</td>
<td>In trauma, dreams are about the child himself dying or being hurt.</td>
<td></td>
</tr>
<tr>
<td>Generalized reaction … SADNESS</td>
<td>Generalized reaction … TERROR</td>
<td></td>
</tr>
<tr>
<td>Grief reactions can stand alone.</td>
<td>Trauma reactions generally also include grief reactions.</td>
<td></td>
</tr>
<tr>
<td>Grief reactions are generally known to the public and the professional.</td>
<td>Trauma reactions, especially in children, are largely unknown to the public and often to professional counselors as well.</td>
<td></td>
</tr>
<tr>
<td>In grief, pain is related to the loss.</td>
<td>In trauma, pain is related to the tremendous terror and an overwhelming sense of powerlessness and fear for safety.</td>
<td></td>
</tr>
<tr>
<td>In grief, a child’s anger is generally not destructive.</td>
<td>In trauma, a child’s anger often becomes assaultive (even after nonviolent trauma, fighting often increases).</td>
<td></td>
</tr>
</tbody>
</table>

**Trauma Reactions are DIFFERENT from Grief Reactions**

**Trauma Reactions OVERPOWER Grief Reactions**

Children can be traumatized by violent or nonviolent incidents. Separation from a parent through divorce or foster care, a family member’s terminal illness or sudden death, exposure to physical or sexual abuse, witnessing drug use, house fire, tornado, flood, earthquakes, or hurricanes, as well as drowning, murder, suicide, and school violence can all be traumatizing incidents.

What Is Trauma-Informed Practice?

became a landmark study, creating new avenues of research into children’s reactions to trauma and suggesting that they could indeed experience clinically significant mind/body reactions following exposure to terrifying events.

In response to the acceptance that children do indeed experience trauma reactions and posttraumatic stress, a variety of methods have been used to address and ameliorate symptoms. Psychodynamic therapy has a long tradition in addressing childhood trauma and has had some success. When successful, it includes two factors: (1) a consistent relationship between therapist and child and involvement of parents or caretakers during treatment, and (2) longer, more intensive intervention to support change, growth, and improvement in developmental achievements. It is also more effective with younger children than with older children and adolescents (Lieberman & Horn, 2005). Evidence from psychodynamic therapy tells us that traumatized children do benefit from stable, consistent relationships with adult caretakers; that trauma recovery takes time; and that early intervention is key to establishing positive attachment and normal developmental gains.

Psychopharmacological interventions have been used with children and adolescents, but knowledge of how these treatments can help young people lags behind that for adults (Foa, Keane, Friedman, & Cohen, 2000). The consensus is that medications may help those who have symptoms so debilitating that confrontation of traumatic memories is difficult. The ongoing study of these treatments with children and adolescents underscores that trauma, particularly repeated events, increases arousal and other reactions. In brief, it supports the fact that the body’s reactions to trauma must be addressed in order to attend to normal developmental functions such as learning and social interaction.

More recently, cognitive behavioral interventions have been applied to the treatment of traumatized children and adolescents. Foa and Kozak (1986) observe that trauma reactions involve a fear network—a set of responses to threatening stimuli and situations that produce a fight, flight, or freeze reaction. In exploring fear reactions, they cite that what differentiates PTSD from anxiety disorders is that trauma is a psychological and physiological state that destabilizes a sense of safety. As a result, experiences that previously felt safe become associated with danger and subsequent fear and terror. This discovery led to increased interest in how intervention could be used to change thinking in individuals with trauma reactions and reduce PTSD through cognitive-behavioral therapy (CBT).

In brief, CBT focuses on the interactions among affect, cognition, and behaviors through identifying errors in thinking and how thoughts influence behavior. CBT has been validated as a treatment of choice for adult victims of trauma (Foa, Rothbaum et al., 1991) and child sexual abuse (Cohen, Mannarino, & Deblinger, 2006; Deblinger, Stauffer, & Steer, 2001). Cohen, Mannarino, and Deblinger (2006) developed trauma-focused cognitive-behavioral therapy (TF-CBT) to address trauma's impact on cognitive functioning.

Many practitioners see limitations in a purely cognitive-behavioral approach to trauma intervention with children and adolescents because of developmental, cognitive, and verbal challenges. Gil (2006) notes that “traumatic events are experienced and stored in the right hemisphere of the brain” and that “this suggests that allowing children a period of time to access and stimulate the right hemisphere of the brain could eventually activate the necessary (explicit) functions of the left hemisphere, which appears to shut down during traumatic experiences” (p. 102). Gil underscores that for many children, forms of CBT may not always be the treatment of choice and may even be counterproductive to the healing process when the dominant processing of trauma experiences is more right brain than left brain.

**Sensory-Based Trauma Intervention**

In response to the challenges of applying CBT in work with children, a variety of approaches have emerged that address the sensory response to trauma rather than only cognitive areas. These include, but are not limited to, somatic experiencing, neurodevelopmental approaches, and experiential therapies such as expressive arts therapies and play therapy.

Levine and Kline (2008) adapt somatic experiencing, a body-awareness approach to alleviating trauma symptoms by restoring self-regulation, to work with children. In brief, it involves “felt-sense experiences” to promote the awareness and release of physical tension. Levine’s approach focuses on fight, flight, or freeze responses that occur during traumatic situations. Techniques include successive titration (slowly helping the individual to release uncomfortable emotions) and pendulation (the movement between regulation and dysregulation (aroused or frozen).

As previously mentioned, Perry and Hambrick (2008) describe the neurosequential therapeutic model (NTM), which also underscores the importance of sensory-based interventions in work with children and adolescents.
In addition to addressing brain development from early childhood through teenage years, this model provides an important structure for choice and application of treatments based on the developmental needs of traumatized individuals. Like Levine’s and similar approaches, NTM highlights the need for experiential interventions and the importance of improving attachments among children and caretakers, empathy, resilience, and self-regulation.

Steele and Raider (2001) describe an evidence-based, sensory integration model called structured sensory interventions for traumatized children, adolescents, and parents (SITCAP™). This approach, according to Gil (2010), is “congruent with trauma-focused play in which children are encouraged to utilize play (primarily drawing in this model) in order to externalize their areas of distress (exposure); to learn to tolerate and release affect (abreaction); and to compensate for injuries and create feelings of mastery (management and restoration of power)” (p. 57). According to this model, trauma is the result of exposure to experiences that are terrifying and leave individuals feeling unsafe and powerless. By introducing traumatized individuals to new experiences that are safe and empowering, trauma reactions can be diminished. The SITCAP model in schools and agencies has demonstrated its efficiency in reducing not only trauma-specific symptoms but also mental health–related reactions (Steele & Raider, 2003; Steele, Raider, Kuban et al., 2008; Raider, 2010).

Finally, expressive arts therapies involving art, music, dance, drama, play, and sand play tray are considered trauma-informed because of their ability to allow for processing of the trauma narrative through nonverbal expressions (Malchiodi, 2005, 2008). The use of art in trauma-related work goes back to the early 1990s when Nader, Pynoos et al. (1990) used drawing to interview children to “identify traumatic imagery and avoidance, to introduce discussion of the child’s individual traumatic experience and to assess the embedded perceptual aspects of the trauma” (p. 379). More recently, art therapies have been most often used to address child abuse (Coulter, 2000; Pifalo, 2002; Klorer, 2008; Malchiodi, 2010) and war and terrorism (Yehidia & Itzhaky, 2004).

According to the International Society for Traumatic Stress Studies (Foa, Keane, Friedman, & Cohen, 2008), these therapies are accepted ways to access nonverbal material and are suited to work with children who have experienced trauma. The main benefit of expressive approaches is their sensory quality—kinesthetic, auditory, and visual—and their relationship to neurological functioning and neurodevelopment (Malchiodi, 2011a). To date, only one small, randomized controlled art therapy study has been conducted (Chapman et al., 2001); this study did
Physicians should be aware that PTSD can occur at any age and can result from a broad spectrum of traumatic experiences. What most physicians would regard as “relatively minor” trauma, such as an eye injury, a single episode of sexual abuse, or an automobile accident, can produce emotional sequelae that may be just as disabling as those produced by experiencing wartime atrocities or being buried alive in a school bus as in the case of the Chowchilla incident described by Lenore Terr (1990).

Although a family physician may not be involved in the immediate treatment of one who has had a traumatic experience, he or she may be the first to detect emotional trauma. The most common symptoms of PTSD are described in an article by Terr. According to Terr, children most often “re-see” their trauma during leisure times, when they are resting, daydreaming, or trying to fall asleep, rather than in nightmares or the characteristic flashback of adult PTSD. Furthermore, children engage in repetitive posttraumatic play that can consist of reenacting a specific aspect of the traumatic event or simply reenacting the violence they experienced, as in this case.

Children exhibit specific fears, which are easier to identify if the traumatic event is known. However, when a child presents with intense fear toward specific objects, individuals, or situations, the physician should carefully obtain a thorough history, even if emotional trauma is not suspected initially. Even fear of mundane things such as the dark, strangers, being alone, being outside, food, animals, and vehicles should be investigated. Traumatic experiences can also change a child’s attitudes about people, life, and the future. Most children possess a great deal of trust and optimism. Phrases such as “Mommy gets mad when I’m bad” or “Daddy can’t always protect me” should alert physicians to the possibility of emotional trauma.

Studies have demonstrated that although most family practice and pediatric residents provide opportunities for parents or children to voice their psychosocial concerns, the residents often respond with information, reassurance, guidance, or referral less than half of the time. Many parents have never heard of PTSD, yet a simple intervention can reduce
What Is Trauma-Informed Practice?

not show significance for art therapy as a method to reduce PTSD over time. Although there is very little empirical evidence to support efficacy of the arts therapies, they have been successfully integrated within CBT sessions with children and in other sensory-based models such as SITCAP (Steele & Raider, 2001).

Finally, play therapy is a sensory-based approach that has, for several decades, been widely applied to the amelioration of trauma in children (Gil, 2006; James, 1989). Approaches emphasize attachment (Booth & Jernberg, 2009; Klorer & Malchiodi, 2003), communication of the trauma narrative (McMahon, 2009), crisis intervention (Webb, 2007), and emotional reparation and recovery (Gil, 2006). Overall, play therapy provides a method of communication and imaginal exposure similar to the expressive arts therapies by capitalizing on props, toys, and self-expression to assist in trauma recovery in children (Malchiodi, 2005).
Emergence of Trauma-Informed Practice

What has been learned from neurodevelopmental findings and sensory-based, somatic, cognitive-behavioral, and expressive therapies over the preceding decade has led to the development of a trauma-informed approach to work with children and adolescents. Recognition that trauma is a central factor in many mental health challenges and disorders is a common denominator in defining current best practices. While individuals react to trauma in idiosyncratic ways depending on the nature of the incidents and a variety of circumstances, trauma often becomes a defining characteristic that affects psychological, social, physical, and cognitive aspects of life, even for its youngest survivors. In fact, trauma reactions in children may be inaccurately identified as depression, attention deficit problems, oppositional defiant disorder (ODD), conduct disorder, anxiety disorders, separation anxiety, or reactive attachment disorder (Cook, Blaustein, Spinazzola, & van der Kolk, 2003).

As previously mentioned, it is widely accepted that long-standing, untreated trauma reactions may result in a variety of medical conditions later in life including heart disease, cancer, and respiratory problems, and social conditions such as homelessness, prostitution, or delinquency (WISQARS, 2010).

Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. The development of the National Center for Trauma-Informed Care (NCTIC) in 2005 is a turning point in understanding trauma’s impact on children and adolescents. NCTIC is funded by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA) and has brought national attention to the prevalence of trauma and the need to create trauma-specific interventions and trauma-informed environments. Its presence brings to light that traditional service delivery may actually exacerbate traumatized individuals and that a comprehensive approach addressing the individual, environment, and service providers is fundamental to trauma recovery. According to NCTIC (2011), the principles of trauma-informed care include:

1. **Understanding Trauma and Its Impact**: Understanding traumatic stress and how it impacts people and recognizing that many behaviors and responses that may seem ineffective and unhealthy in the present represent adaptive responses to past traumatic experiences.
2. **Promoting Safety:** Establishing a safe physical and emotional environment where basic needs are met, safety measures are in place, and provider responses are consistent, predictable, and respectful.

3. **Ensuring Cultural Competence:** Understanding how cultural context influences one’s perception of and response to traumatic events and the recovery process, respecting diversity within the program, providing opportunities for consumers to engage in cultural rituals, and using interventions respectful of and specific to cultural backgrounds.

4. **Supporting Consumer Control, Choice, and Autonomy:** Helping consumers regain a sense of control over their daily lives and build competencies that will strengthen their sense of autonomy; keeping consumers well informed about all aspects of the system, outlining clear expectations, providing opportunities for consumers to make daily decisions and participate in the creation of personal goals, and maintaining awareness and respect for basic human rights and freedoms.

5. **Sharing Power and Governance:** Promoting democracy and equalization of the power differentials across the program; sharing power and decision making across all levels of an organization, whether related to daily decisions or in the review and creation of policies and procedures.

6. **Integrating Care:** Maintaining a holistic view of consumers and their process of healing and facilitating communication within and among service providers and systems.

7. **Healing Happens in Relationships:** Believing that establishing safe, authentic, and positive relationships can be corrective and restorative to survivors of trauma.

8. **Recovery Is Possible:** Understanding that recovery is possible for everyone, regardless of how vulnerable they may appear. Providing opportunities for consumer and former consumer involvement at all levels of the system, facilitating peer support, focusing on strength and resiliency, and establishing future-oriented goals.

Trauma-specific interventions are designed specifically to address the consequences of trauma in the individual and to facilitate healing. Treatment programs using a trauma-informed approach generally: recognize that survivors need to be respected, informed, connected, and empowered; help to reinforce hope in the recovery process; emphasize the interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders,
depression, and anxiety); and encourage collaborative work with survivors, their family and friends, and other human services agencies.

In work with children and adolescents who experience sexual abuse, physical abuse or neglect, or are witnesses to interpersonal violence, Malchiodi (2011b) notes that trauma-informed practice integrates neurodevelopmental knowledge and sensory intervention, such as art and play therapy and other experiential approaches, in trauma intervention. In general, a trauma-informed approach must take into consideration, but is not limited to, the following: (1) how the mind and body respond to traumatic events, (2) recognition that symptoms are adaptive coping strategies rather than pathology, (3) emphasis on cultural sensitivity and empowerment, and (4) helping to move individuals from being not only survivors, but ultimately to becoming thrivers through skill building, support networks, and resilience enhancement. In regard to the latter, trauma-informed practice also clearly dictates that treatment be individualized and supported by comprehensive trauma assessment to determine the impact on all aspects of functioning. This includes specific, strength-based aspects of not only the child, but the family, community, and culture/environment in order to design a comprehensive action plan to address the effects of trauma (Malchiodi, 2011b).

In brief, a great deal of research has recently emerged to support the development of interventions that address mind–body and cognitive responses to trauma as well as enhance strengths and needs of traumatized children and adolescents. Witness Justice, a resource for victims (2010), summarizes (in their health and wellness section under the title, *Trauma Is the Common Denominator: New Discoveries in the Science of Traumatic Behavior*, http://www.witnessjustice.org) the impact of trauma as follows:

> When experienced in childhood, trauma produces neurobiological impacts on the brain, causing dysfunction in the hippocampus, amygdala, medial frontal cortex and other limbic structures. When confronted with danger, the brain moves from a normal information-processing state to a survival-oriented, reactive alarm state. Trauma causes the body’s nervous system to experience: an extreme adrenaline rush; intense fear; information processing problems; and a severe reduction or shutdown of cognitive capacities, leading to confusion and defeat. … The healing journey is now seen to include biological as well as psychological transformation.
Trauma-Informed Care: Best Practices

There is no one intervention that fits every situation. At first glance, the numerous variables practitioners face when providing intervention seem overwhelming because successful care must address the biological, physiological, neurological, and psychological aspects of trauma. Developmental differences, age, gender, settings, medications, diversity, socioeconomic conditions, and social support all affect outcomes. Interpersonal trauma, medical illness, disasters, and early attachment disruption are significant factors that challenge intervention. Some children do better with individual interventions while others flourish within group settings; some will require long-term care while others may experience rapid posttraumatic growth due to personality and resiliency. Additionally, practitioners’ education, commitment, and understanding of trauma reactions as well as their own vulnerability to secondary trauma reactions can make a difference in successful trauma-informed care.

If there are multiple interventions and practice variables to consider, what should guide the development and application of treatment? To be trauma-informed means that assessment and intervention are based on principles that are supported by best practices and research in trauma-informed care. There is general agreement that these principles include, but are not limited to, the following:

1. Restore a sense of safety, empowerment, and self-regulation (Bath, 2008; Briere & Scott, 2006; Perry & Szalavitz, 2006; Greenwald, 2005).
2. Apply trauma-informed assessment through an understanding of neurosequential development and sensory-based trauma reactions.
3. Capitalize on interventions that address the right hemisphere of the brain (Gil, 2006).
4. Develop trauma-informed relationships between child clients and therapists, parents/caretakers, teachers, and other helping professionals and significant adults to establish positive attachment and improve interpersonal skills.
5. Create trauma-informed environments that support internal locus of control, positive social interaction, safety, and empowerment.
6. Promote trauma integration to help individuals reach a new meaning for trauma events and capability to manage trauma reactions (Steele & Raider, 2001).
7. Encourage posttraumatic growth and resiliency (Malchiodi, Steele, & Kuban, 2008) and positive affective enhancement (Cook, Spinazzola, Ford et al. 2005).
8. Recognize that no one intervention fits every situation and that in the course of intervention, trauma integration results from the timely and developmentally appropriate application of sensory-based, somatic, cognitive, and behavioral approaches and practices.
9. Develop and include interventions that respect and support cultural diversity.
10. Empower children and adolescents and their families/caretakers to become active participants in intervention and programming.

Cultural Implications for Trauma-Informed Practice

In terms of cultural sensitivity and competence, best practices and research data on applications is still emerging. The following is a list of recommendations based on the current literature and best practices on effective intervention across cultures:

1. Intervene earlier rather than later to achieve greater and more sustainable gains (Cicchetti, Rogosch, & Toth, 2006).
2. Apply psychoeducational parenting interventions to improve social and family relationships and educational achievement (Boden, Horwood, & Fergusson, 2007).
3. Ethnically match the professional to the client whenever possible and when not possible, use and supervise ethnically matched paraprofessionals to assist with intervention (Snowden, Hu, & Jerrell, 1995).
4. Provide support services to children to assist with acculturation in school.
5. Avoid using children to interpret for parents.
6. Facilitate connections to ethnically matched support groups during intervention.
7. Always determine what is and is not culturally acceptable regarding recommendations and/or expectations you present.
8. Determine the expectations all clients (adults, families, and children) have regarding service and outcome.
9. Attempt to assess what change will mean in that individual’s or family’s cultural context and evaluate their cultural acceptability.
10. Obtain the intergenerational history of trauma and its impact on behavior and psychological factors. Understand that even within a specific culture, trauma experiences may differ and call for a different intervention focus.

Conclusion

Trauma-informed practice with children and adolescents requires the integration of the principles presented in this chapter along with best practices in the field. This chapter has underscored the importance of not only how trauma influences mind and body, self-regulation, and trauma integration, but also the impact of relationships, environment, and development throughout childhood and adolescence. Each of these aspects is critical to creating individualized and comprehensive trauma-informed care that addresses the sensory experiences of young clients who are traumatized.

Because any effective intervention requires an accurate evaluation of trauma and its effects, the next two chapters provide overviews of trauma-informed assessment. While evaluation often involves determining the deleterious effects of trauma on individuals, a trauma-informed approach dictates that helping professionals identify survivors’ adaptive coping strategies rather than a pathology-only viewpoint. It also includes an understanding of developmental, cultural, relational, and environmental factors affecting traumatized children and adolescents, with the ultimate goal of helping them move from survivors to thrivers.