Trauma Matters: Addressing Inter-generational Trauma and Breaking the Cycle through Treatment Courts

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SESSION LEARNING OBJECTIVES

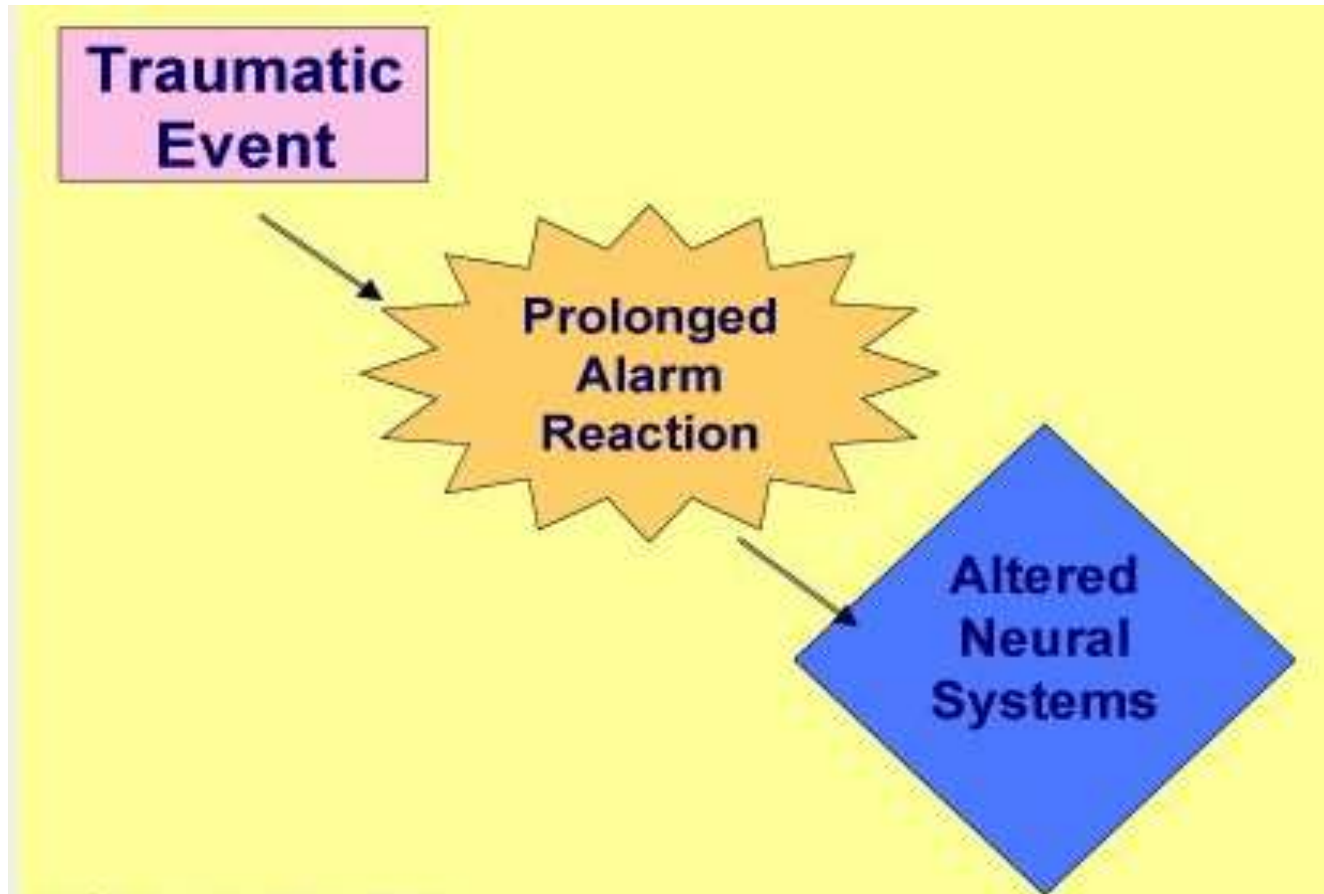
1) Describe different types of trauma and its biologic explanation

2) Explain why intergenerational trauma cycles are difficult to break and steps court teams can take to effectively intervene

3) Identify what "counts" as traumatic exposures for children, youth, and adults and how it might explain some behaviors.

4) Identify at least two trauma-informed / trauma-competent care strategies you can use to improve your court practices and reduce intergenerational trauma

Trauma can be induced by experiences that lead to abnormally intense, prolonged stress responses



Trauma can be experienced directly (primary) or secondarily – by hearing about it or bearing witness to its effects

Are we experiencing more trauma?

More secondary, vicarious trauma?

24-hour "News" Cycle,

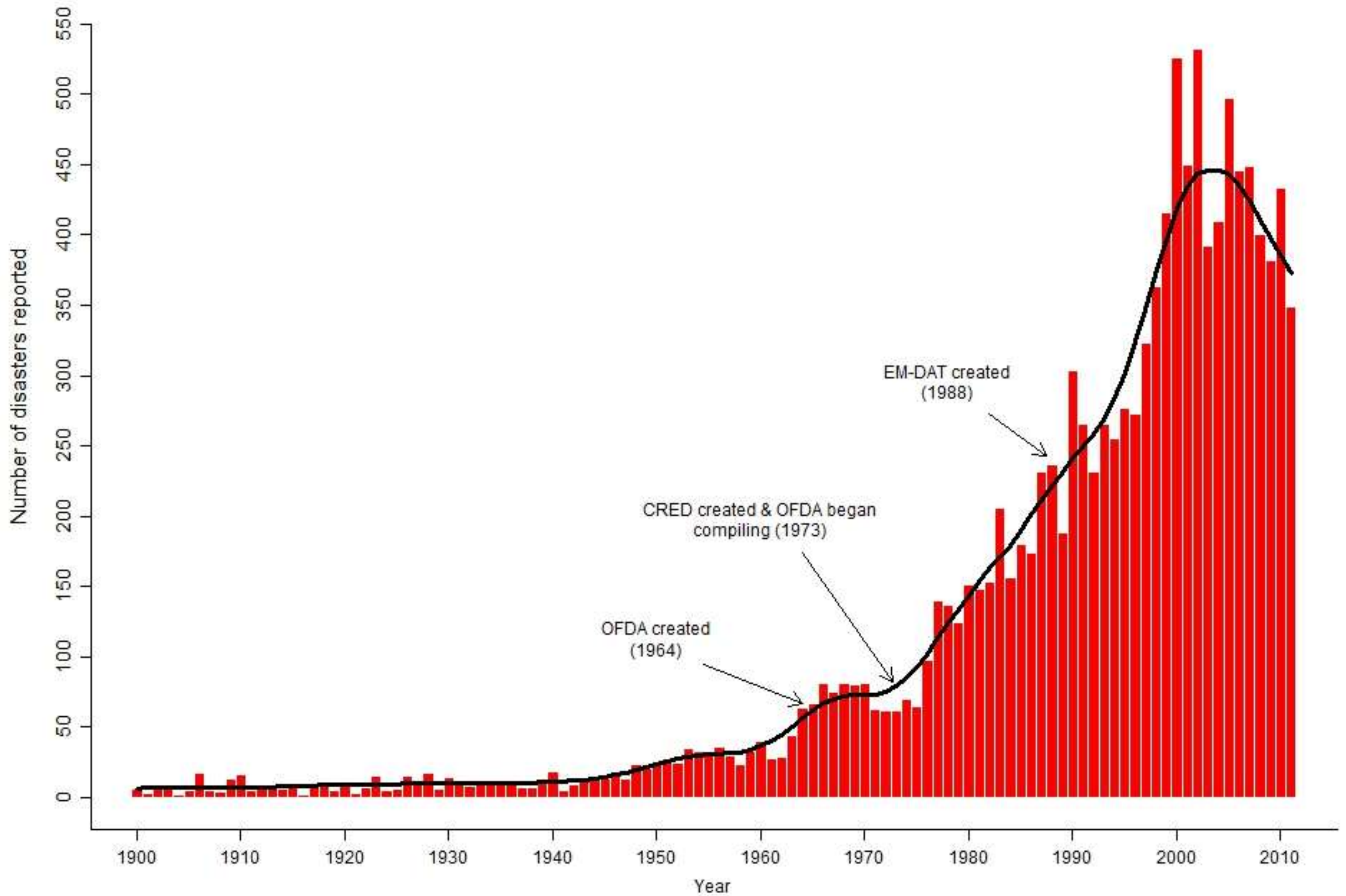
+ constant social media, = overload, "burnout", fear, anxiety, increased stress, vicarious trauma

Sheriff: Vet Shot Himself After Killing 3 Mental Health Workers in Yountville
March 15, 2018 at 11:07 pm

Suicide rates are particularly high in rural parts of California where mental health care is scarce. Trinity County saw an annual rate of more than 30 suicides per 100,000

Downtown St. Louis being hit by a wave of drug overdoses NOVEMBER 10, 2017,

Heroin overdoses are becoming all too common.
USA TODAY NETWORK, **USA TODAY**



Natural disasters reported 1900 - 2011
Number of disasters reported
0
50
100
150
200
250
300
350
400
450
500
550
1900
1910
1920
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1940
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1990
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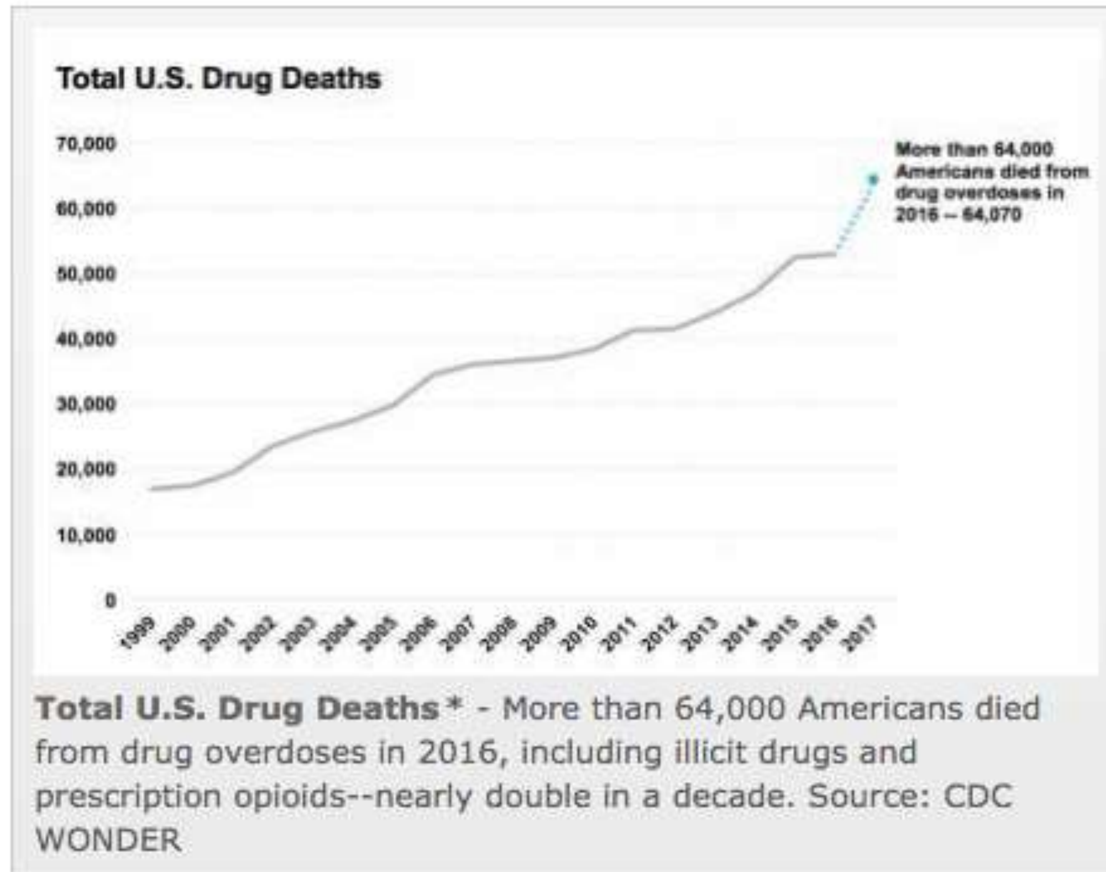
2010
Year
OFDA created
(1964)
CRED created & OFDA began
compiling (1973)
EM-DAT created
(1988)
EM-DAT: The OFDA/CRED International Disaster Database - www.emdat.be - Université Catholique de Louvain, Brussels - Belgium

Fatal Drug Overdoses Increasing



Total U.S. Drug Deaths * - More than 64,000 Americans died from drug overdoses in 2016, including illicit drugs and prescription opioids--nearly double in a decade. Source: CDC WONDER

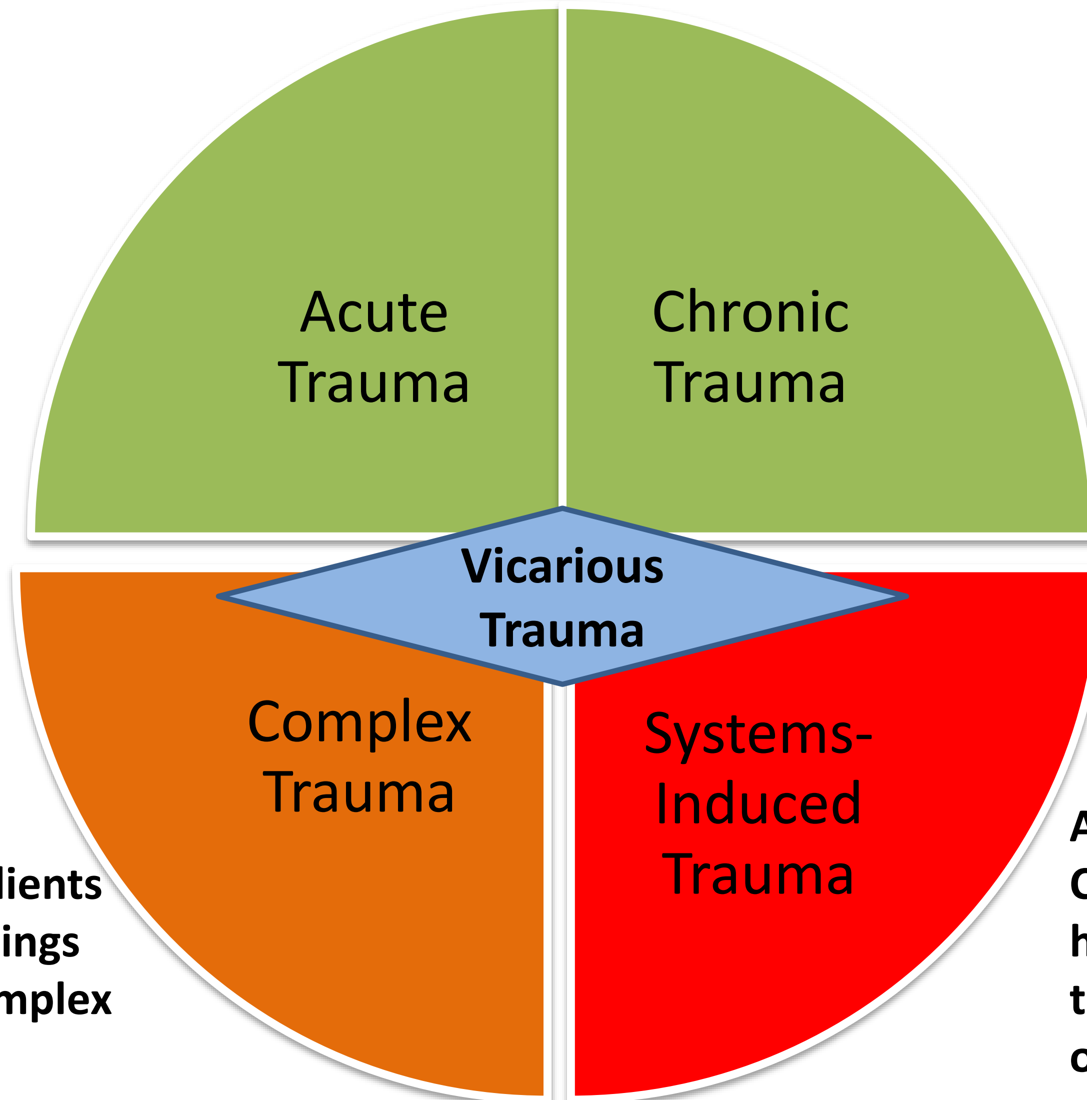
* Provisional counts for 2016 are based on data available for analysis as of 8/2017. Counts through 2015 are based on final annual data.

In 2016, est. 64,070 died from drug overdoses

Trauma increasingly viewed as a “Hidden Epidemic” – may be “endemic”

- It’s Unseen, but likely at the root of
  - Anxiety Disorders
  - Depression
  - PTSD
  - Addictions
  - OCD, other compulsions, & impulse control disorders
  - Risk-taking
  - Suicidality & non-suicidal self-injury
  - Re-victimization
  - Attachment and relationship difficulties

Types of Trauma



MOST of adult clients in our Court settings present with Complex Trauma

As managers of our Court systems, we have the responsibility to avoid re-victimizing our clients

Trauma Definitions

- **Acute Trauma*:*** Single, time-limited traumatic event exposure (rape, car accident, etc.)
  - Resilience is high; 75%+ recover almost fully
- **Chronic Trauma*:*** Multiple, possibly varied traumatic event exposure (war exposure, ongoing physical abuse, etc.)
- **Complex Trauma*:*** Term is used to discuss both exposure to chronic trauma & impact of trauma
  - Disruptive to mind, body, spirit= Symptoms, Disorders
  - ~75% sustain continuous symptomology

CWC/NCTSN, 2008

Other Types of Trauma

- Group Trauma
  - Military, first-responders (police, firefighters, emergency personnel, etc.), gang members
- Mass Trauma
  - Hurricane Katrina, Refugees, War survivors
- Interpersonal Trauma
  - Intimate partner violence, child molest and abuse
- System-Induced Trauma
  - Usually involves re-victimization, in which organized systems create trauma, including those designed to mitigate trauma (foster care, rape victim interviews, law enforcement and court actions, juvenile detention facilities, etc.)

Intergenerational and Transgenerational Trauma

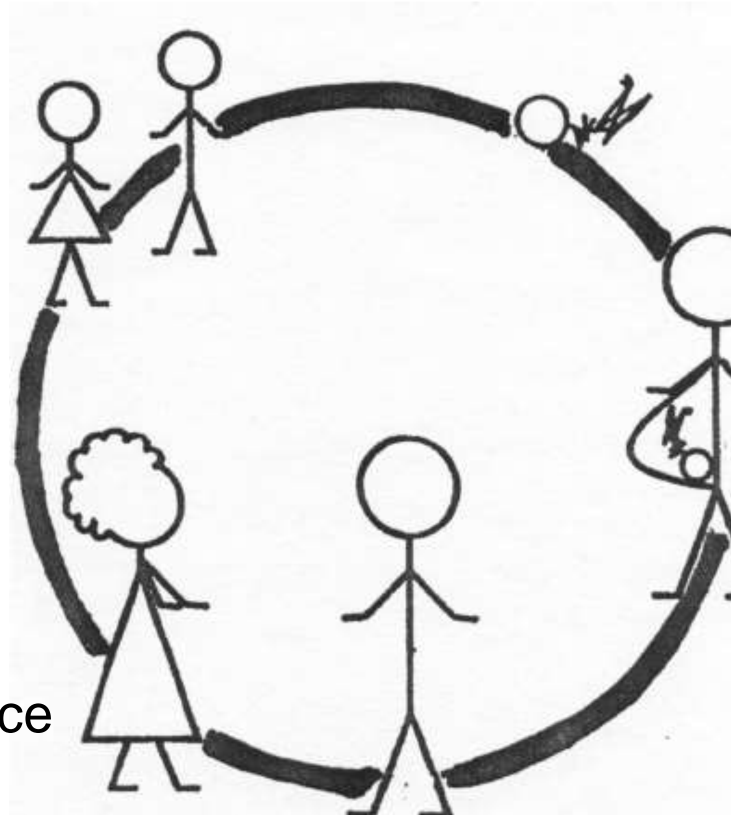
- **Intergenerational trauma**
  - Wounding across generations resulting from previous traumatic exposures, including war experiences, chronic violence exposure, and historic events, such as societal disruptions, colonization (Walters, 2015)
- **Complex Transgenerational Trauma**
  - Involves epigenetics, may involve ongoing, reactivating traumas, societal triggers
- **Historical Trauma**
  - Japanese internment camps, First People's genocide, African American slavery

Family Disease of SUDs, CODs, Violence

Intergenerational Trauma

Children
COA Roles
Neglect and abuse
Biologic vulnerability

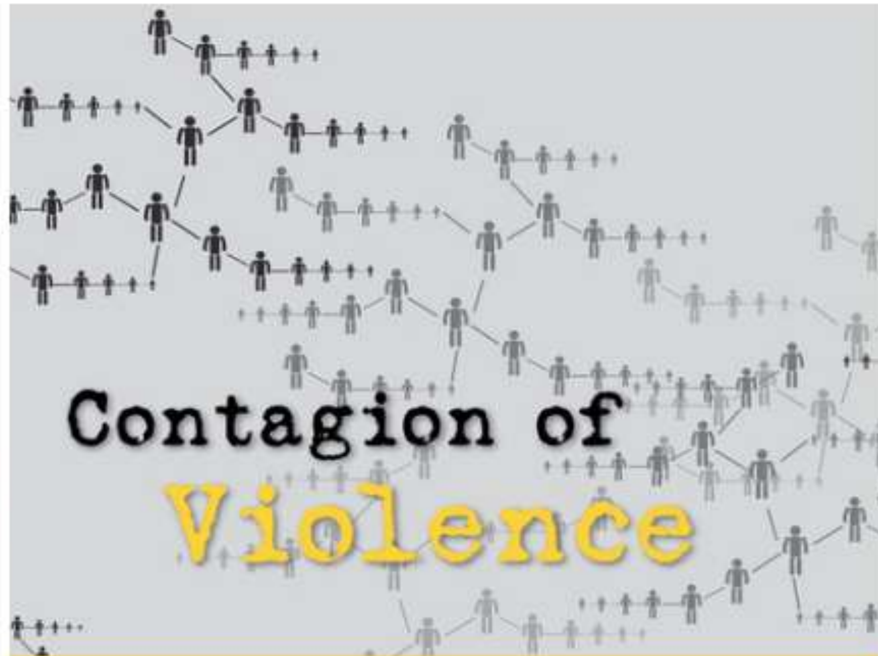
Grandma/Extended Family
Drug/alcohol dependence and codependence



Fetus/Infant
Intrauterine toxicity
Neonatal toxicity / withdrawal
Increased muscle tone
Neglect/abuse

Mother
Drug/alcohol dependence and codependence
COA issues
Pregnancy complications

Father
Drug/alcohol dependence



WORKSHOP SUMMARY

INSTITUTE OF MEDICINE AND
NATIONAL RESEARCH COUNCIL
OF THE NATIONAL ACADEMIES

To TREAT a disease, we must first have a CORRECT diagnosis.

Mis-diagnosis leads to ineffective & even damaging and counter-productive control strategies and treatments.

Moralistic views usually fill gaps in scientific knowledge or understanding.

Drug addicts were bad people,
Lepers were sinners,
People infected with ebola or bubonic plague were disfavored by the gods or inhabited by demons

Violence Begets Violence

More than a Metaphor: Epidemiology & Neuroscience

- Violence is a health problem
  - Brain based
  - Brain acquired
  - Trauma facilitated
  - Contagious
- **Both** those engaged in it and affected by it have a health issue
- Repeated exposure can hardwire dissociative and hyperarousal responses to violence into the brain (Perry, 2001)

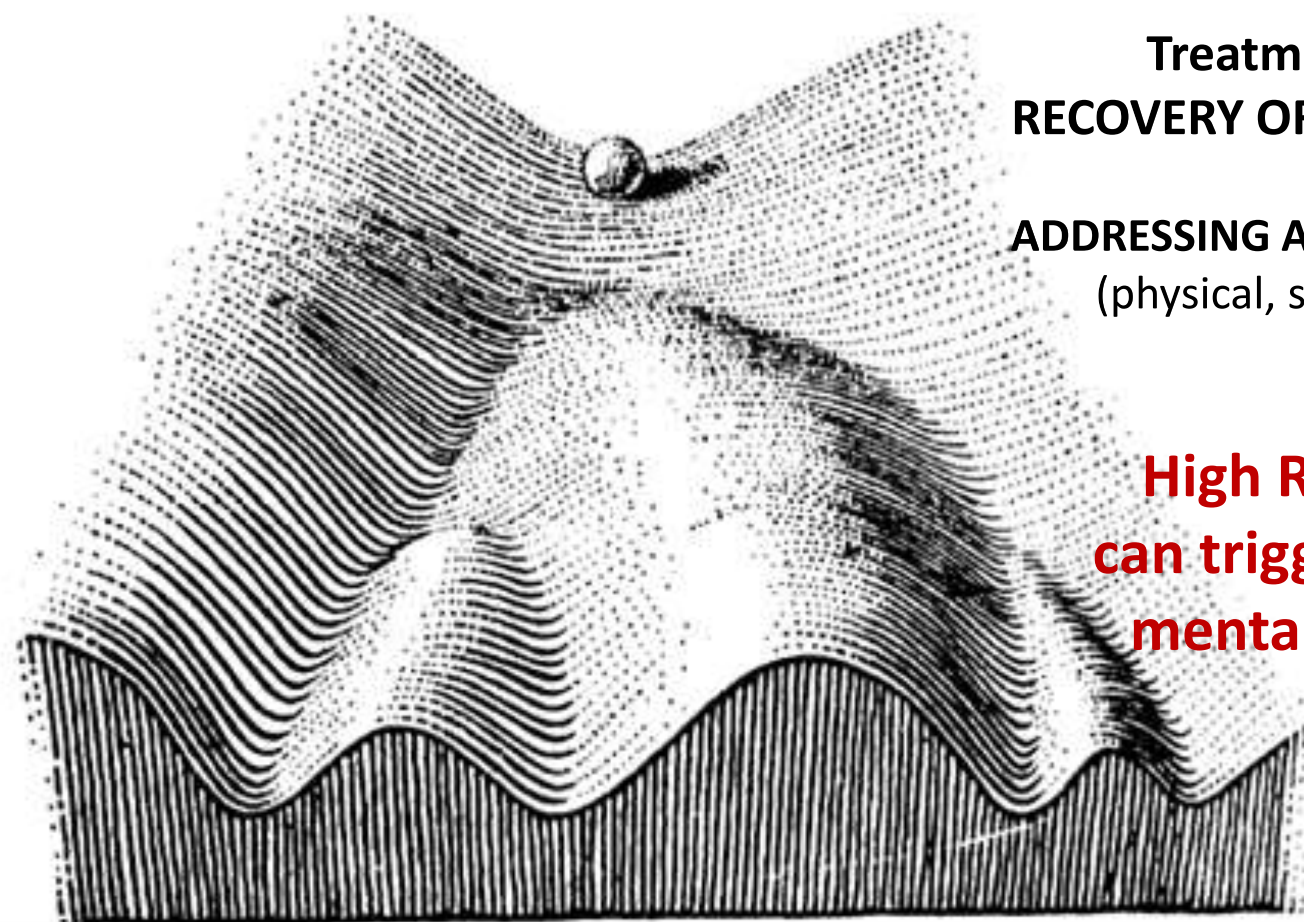
Violence is Transmissable

- Those chronically exposed to violence were **30x more likely** to engage in violence
- People exposed to violence – either by witnessing or being subjected to violence themselves – are more likely to become perpetrators of violence (BOTH Victim & Vector)
- AND there is a DOSE DEPENDENCY between exposure and likely expression of violence
- Strong evidence across *all* types of violence: IPV, child abuse, community violence, suicide, etc.

Slutkin, G. *Cure Violence*. Envisioning Criminology. ED M Maltz & S Rice. 2015

The Epigenetic "Landscape"

"Nature" (eg: genetic makeup)
AND "Nurture" (eg: environment)
Influence Our Lives



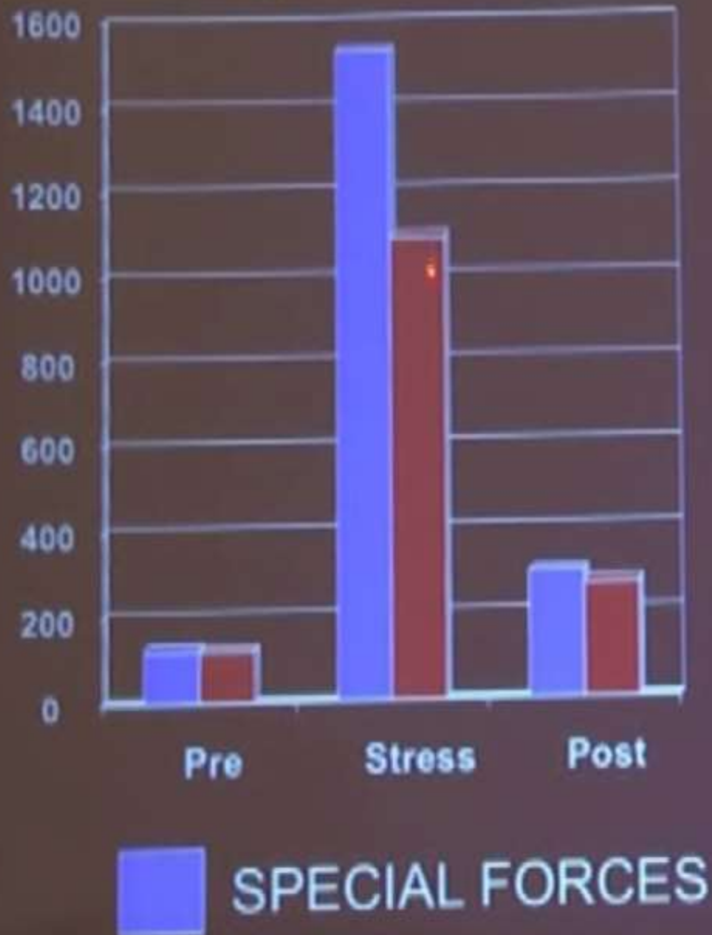
Treatment Courts should be
RECOVERY ORIENTED SYSTEMS OF CARE
HOLISTIC
ADDRESSING ALL ASPECTS OF PERSON'S LIFE
(physical, social, emotional, spiritual, vocational)

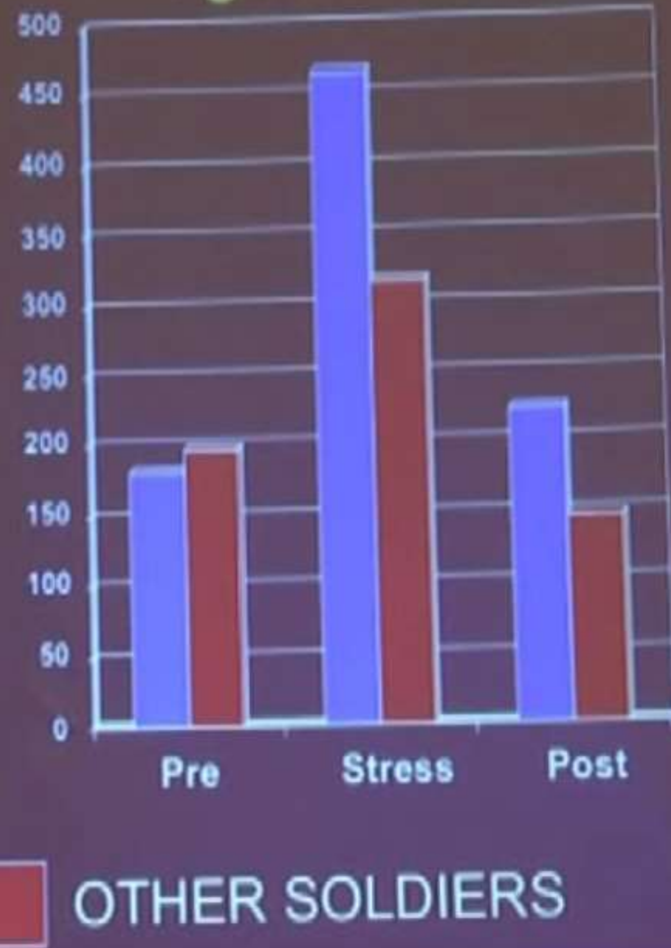
High Risk Environments can trigger poor health and mental health outcomes

Waddington, 1977

Military Training in Selective Violence is Rigorous - & Individual Service Member Variability is Wide

EG: Individuals with PTSD consistently have lower levels of neuropeptide Y – so the recovery from the adrenaline (among other things) is much slower to shut down – compromising capacity for resilience





Levels of Adrenaline **Levels of Neuropeptide Y**

Trauma, Violence, & Substance Abuse

- Children & youth are at highest risk for being victims of violence (3x adult rate) -> trauma
- Trauma exposure correlates with:
  - Self-medication, often substance abuse with high risk behaviors
  - Substance use associated with injuries, and violence – as both perpetrator and victim
- Courts with "High Risk/High Need" Population Have Clients with Trauma

Immunity & Herd Immunity

- Resistance to exposure to violence (immunity) can be conferred by a family or peer environment in which views, behaviors, and norms against violence are very well established and maintained

- Alternative responses to violence are well supported, in particular, among close peers (biologically, among those who would either be competitors or allies for community well-being)

PTSD Prevalence Estimates in populations we work with

- Rates of PTSD in juvenile justice-involved youth: (est 60% have dx MH disorders)
- Rates of PTSD in women's substance abuse programs: 20-50%
- Rates of PTSD in returning military service members from OIF and OEF: 22 – 37%
- **Trauma Exposure is NOT randomly distributed in the general population –**
- **People with High Rates of Trauma Exposure are Concentrated in our Courtrooms & Jails**

For Example: Complex PTSD

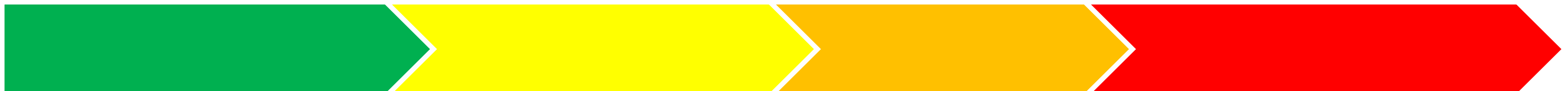
- *PTS occurs on a spectrum*
  - Partial experiences may occur in certain domains

  Eg: only nightmares, but no awake re-experiencing (no flashbacks, etc.)
- *Traumatic experiences over time affect individuals differently* (clearly manifest in somatic illness) One aspect of trauma currently being addressed can activate *another* area of traumatic experience

  Eg: processing adult traumatic events can be complicated by *triggering* unmanaged childhood traumatic exposures

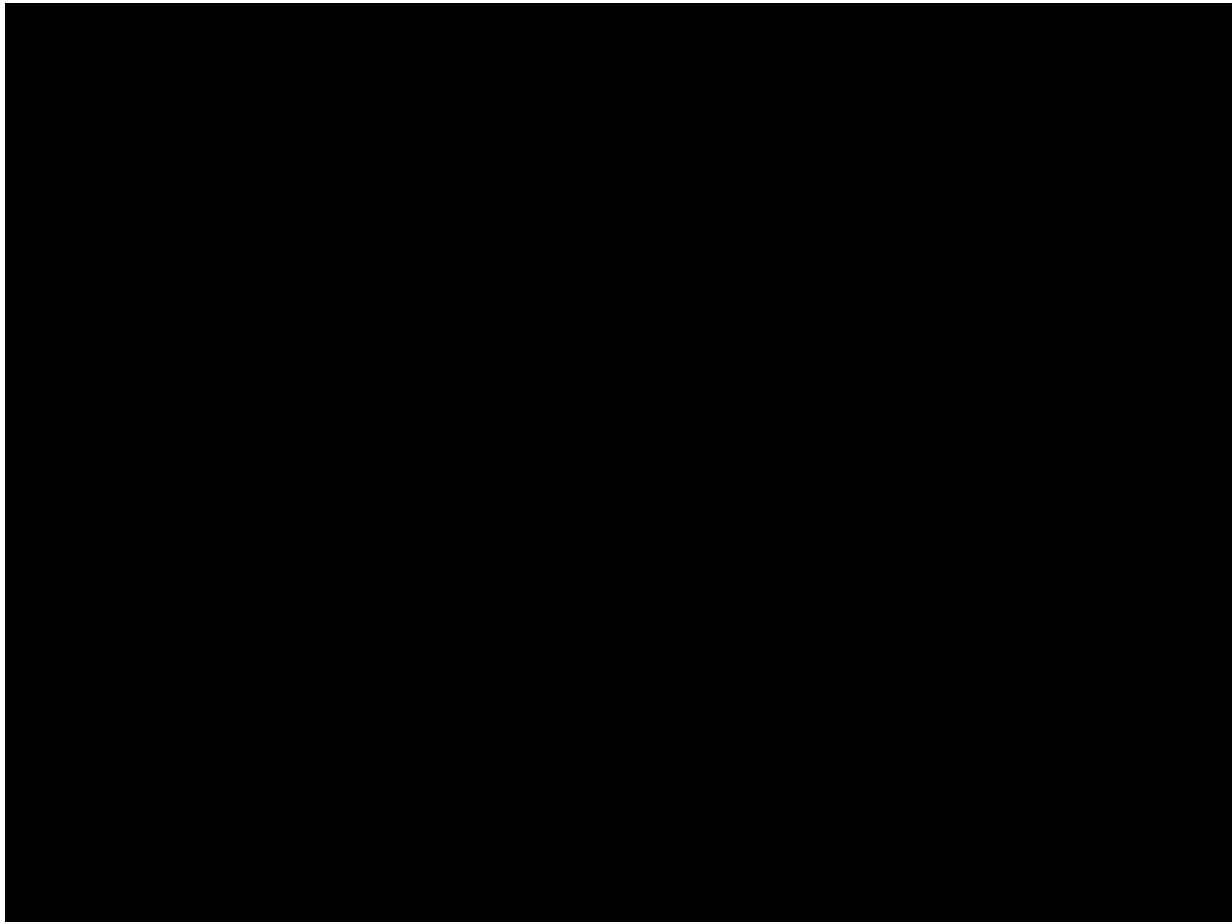
Post-Traumatic Stress Disorder (PTSD)

- Characterized by three main symptom clusters that manifest following exposure to the traumatic event.
  - Re-experiencing Symptoms
  - Avoidance and Numbing Symptoms
  - Hyper-arousal Symptoms



Post Traumatic Stress Disorder – major domains

- When stress doesn't go away after bad experiences (confrontations, accidents, chronic stress, verbal abuse, attacks, use of force, etc.)
- **Re-experiencing**
  - *Intrusive memories, flashbacks*
  - *Nightmares*
- **Hyperarousal**
  - *Fear* when exposed to reminders
  - *Physiologic arousal* (startle responses)
  - *Insomnia* – excessive alcohol consumption is used to self-medicate for this and other aspects of PTSD – coupled with reactivity this leads to problems
  - *Irritability/reactivity* – can be problem when one has been trained to react quickly, or be aggressive
- **Avoidance** (breeds avoidance)
  - *Numbing, anhedonia* (elements of depression and anxiety as part of PTSD)
  - *Active avoidance* of possible triggers – so life becomes more constricted
  - *Hyper-reactivity* to the traumatic reminders; triggers can become more potent as the individual avoids them (so fails to become desensitized even in safe context -- thus, the basis for Prolonged Exposure Therapy PET)



Post-Traumatic Stress

Adverse Childhood Experiences (ACE) Study Findings & SUDs

Each ACE increased the likelihood for early initiation of drug use 2 to 4-fold

Individuals with 5 or more ACEs were 7 to 10-fold more likely to be have Substance Use Disorders (SUDs)

Effects of ACEs *outweigh* increased drug access, attitudes towards drugs, and public education campaigns to prevent drug abuse for *4 successive cohorts back to 1900*

ACE: a retrospective study of 8,613 adults interviewed re: original ACE 8 categories:

Childhood Abuse (3 items: emotional, physical, sexual),

Household Dysfunction (5 items: substance abuse, mental illness/depression/suicidal, battered mother, incarcerated family member, at least 1 biologic parent died before subject 18 yrs)

10 ACES Survey Questions

While you were growing up, during your first 18 years of life:

1.Did a parent or other adult in the household often or very often… ***Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?*** Yes /No If yes enter 1

2. Did a parent or other adult in the household often or very often… ***Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?*** Yes/ No If yes enter 1

3.Did an adult or person at least 5 years older than you ever… ***Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?*** Yes/ No If yes enter 1

4. Did you often or very often feel that … ***No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?***

Yes/ No If yes enter 1

5. Did you often or very often feel that … ***You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?*** Yes /No If yes enter 1

6. **Were your parents ever separated or divorced?** Yes/ No If yes enter 1

7. **Was your mother or stepmother*: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit at least a few minutes or threatened with a gun or knife?*** Yes/ No If yes enter 1

8. ***Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?*** Yes/ No If yes enter 1

9. ***Was a household member depressed or mentally ill, or did a household member attempt suicide?*** Yes /No If yes enter 1

10. ***Did a household member go to prison?*** Yes No If yes enter 1

Now add up your "Yes" answers: _______ This is your ACE Score

ACEs Connection - Healthy

acesconnection.com

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Share Media Torrent

Sign Up Sign In Search ACEs Connection

aces connection

HEALTHY, HAPPY KIDS GROW UP TO CREATE A HEALTHY, HAPPY WORLD.

MAIN GROUPS MY PAGE MEMBERS EVENTS VIDEOS PHOTOS FORUM BLOGS ACESTOOHIGH.COM

This community of practice uses trauma-informed, resilience-building practices to prevent Adverse Childhood Experiences & further trauma.

MEMBERS

View All

EVENTS

Welcome to ACEs Connection

Sign Up

or Sign In

LATEST ACTIVITY

Teresa Moore and Tim Clement joined Jane Stevens's group

Community Managers

Groups' community managers develop and exchange best practices to grow and facilitate t

Sign in to chat!

Vincent Felitti, MD, Director, study, Kaiser Permanente CA

www.acesconnection.com

Three components (circuitry) of the CNS Involved in Extreme Stress & Trauma

1 Autonomic Nervous System (in the medulla oblongata - brainstem) coordinates functioning of organs of the body

- **Sympathetic** side: “fight or flight”
- **Parasympathetic** side: “feed or breed”

2 Amygdala

- Threat memory system
- Threat alarm system

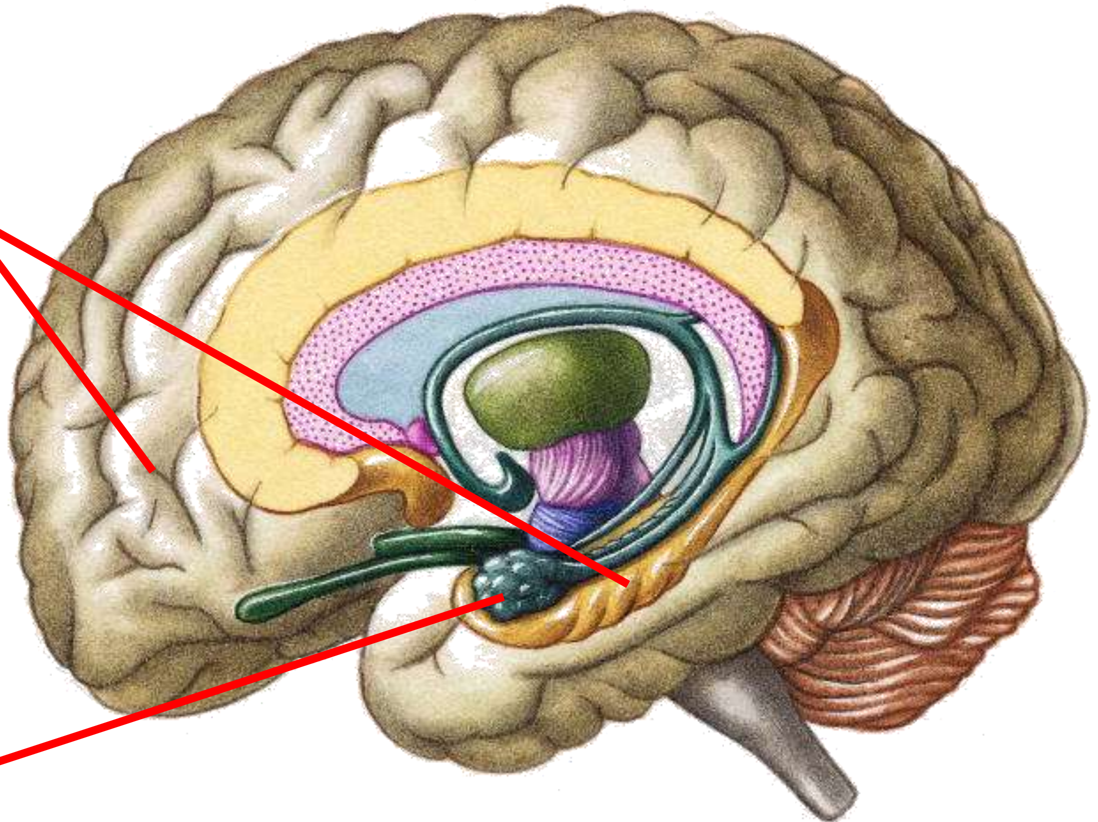
3 Hippocampus and **prefrontal cortex (PFC)**

- Self-control system
- Declarative memory storage and recall
- HC is very stress-vulnerable part of brain

Brain Centers Affected by Traumatic Stress

HIPPOCAMPUS & PREFRONTAL CORTEX

Major memory and self-control system



AMYGDALA

Threat alarm system

Traumatic Brain Injury (TBI)

- A blow or jolt to the head that disrupts the function of the brain
- Not all blows or jolts result in TBI
- Severity is determined at the time of injury
  - Mild -- also called "concussion"
  - Moderate
  - Severe

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MTBI = Increased Risk for Addiction-Related Disorders

- Within first 30 days after mTBI, the odds ratio for drug dependence is 7.7; for Opioid dependence is 6.1; for amphetamine is 4.8; for alcohol is 3.5
- All odds ratios EXCEPT for ALCOHOL & Opioid Dependence/Abuse decrease over time
- ETOH, drug, nicotine, caffeine, and nondependent abuse of drugs/ETOH were all elevated in 1-30 days; ALCOHOL persisted
- SUDs Screening is therefore warranted at both short- and long-term milestones following mTBI
- TBI survivors are known to have blunted dopamine systems

"Risk for Addiction-Related Disorders Following Mild Traumatic Brain Injury in a Large Cohort of Active-Duty U.S. Airmen". Miller, S. et al. ,Am J Psych. April 2013

The “fall-out” of traumatic exposures is in your Courtrooms

- Physical Trauma -> TBI and PTS/PTSD
- Physical and other traumatic exposures -> PTS/PTSD and TBI
- TBI and PTSD often co-occur
- TBI and PTSD -> Self medication with alcohol, pain meds, illicit meds -> Substance Use Disorders
- SUDs -> “run-in” with law enforcement
- SUDs + CODs of TBI and/or PTSD/PTS -> “bad”/ inappropriate interactions with authorities and others
- SUDs and CODs of TBI and/or PTSD/PTS -> Mental Health Disorders induced by combination of all above
- -> **COMPLICATED CASES**

Collaborative Court Populations

- Foster care history, other family displacements
- Families with highest Trauma Histories, including intergenerational trauma, related to status and race
- Generations of low income, and housing instability
- Substance Use Disorders (SUDs)
- Mental health challenges
- Poor physical health
- Family violence and Intimate Partner Violence (IPV)
- Disproportinately the most under-resourced families in our communities

Working with law enforcement, social services, judicial systems, mental health, substance use disorder treatment, and community violence services exposes us to families, youth, and children experiencing intergenerational trauma on a daily basis.

Some Common Short & Long Term Reactions to Traumatic Experiences

- Helpless, hopeless, uncreative
- Angry and cynical
- Inability to empathize or sympathize
- Sense of threat, fear, persecution; can develop into belief that world is unsafe
- Dissociation
- Hyper-vigilance
- Inability to deal with complexity, & minimizing
- Chronic fatigue, pain, ill-health

Common Behaviors of Traumatized Youth in Court

- “I don’t care” attitude
- Refusal to look at the judge
- Profanity
- Refusal to participate in proceedings
- Inability to sleep
- Inability to focus at school
- Fear of others in the community, at school and in detention
- Self-medication with pot, alcohol, cigarettes and other drugs
- High Risk Behaviors – sex, self-harm/suicide

SAMHSA recommends

Integrated Treatment and

Recovery-Oriented Systems of Care

to simultaneously address

Mental Health & Substance Use Disorders

each within the context of the other disorder

Hope– Belief in process & reality of recovery is essential to success

Person-Driven- Individuals create recovery paths, takes courage! -- **Many Pathways**

Holistic– Every aspect of ones life

Peer Support-Others to turn to

Relational- +++ Emotional bonds

Culture-Influential values/beliefs

Addresses Trauma- MUST be treated for recovery to be lasting

Strengths/Responsibility-Build up individuals; Communities step up

Respect-Reduce stigma & shame

EVIDENCE-BASED
Cognitive-Behavioral INTERVENTIONS to reduce anxiety, increase coping, & build resilience

- **Psychoeducation**: for individuals & family/ support system
- **Cognitive processing** skills; eg: problem solving
- **Personal empowerment** training (eg: goal setting)
- **Emotional Regulation** Skills (eg: use of "feeling thermometer")
- **Communication** (assertive "I" based)
- Trauma **narrative** and/or Family Timeline (meaning development)
- **Trauma and Loss Reminder** Management

Examples: FOCUS Project at UCLA

Factors in Recovery & Resiliency or Symptom Development

- Ability to Bounce Back
- **Pre-quel** – Pre-existing Life Experiences
- **Cumulative issues**: intensity, frequency, duration (chronicity/acuity, respite, etc)
- **Coping skills:** acquired, learned, modeled, internalized
- Ability, access, and willingness to seek mental/behavioral health help (ignorance, stigma, fear, shame)

Good News:

- Our brains can heal and grow throughout our lives; neuroplasticity is the capacity of the brain to change by learning
- **Social systems can change via the learning of their individual members**
- **At a systems level, Courts can develop trauma-informed practices and a TIC culture to help end cycles of Intergenerational Trauma.**

To Create Trauma Informed Care in Drug Courts, Consider Two Levels:

- Organizational Response
  - Responsibility to clients
  - Responsibility to co-workers

- Personal /Professional Response
  - Responsibility for self
  - Responsibility for relationships with intimate connections, family, friends, and community

Trauma-informed approach to practice in Drug Courts
(and team organizations)

Involves 3 elements:

1) ***Realize*** the prevalence of trauma

2) ***Recognize*** how trauma affects all individuals involved with the Drug Court - including each member of the Team

3) ***Respond*** by putting knowledge into practice to create a culture of safety and minimize re-traumatization and trauma triggers

Trauma-Informed Care (TIC) is recognized as an Evidenced-Based Best Practice

- Trauma Informed Care is an approach to Court conduct and treatment "that involves understanding, recognizing, and responding to the effects of all types of trauma.
- TIC emphasizes physical, psychological and emotional safety for *both* consumers and providers, and helps survivors rebuild a sense of control and empowerment."
- **TIC asks not "what's wrong with you?" but "what happened to you?"**

TIC

- Trauma Informed Care also aims to reestablish a sense of empowerment that the client –and provider- has lost through trauma - and institutional, collective trauma
- This approach and manner of treatment recognizes “the survivor’s need to be respected, informed, connected, and hopeful (regarding their own recovery).”
  - (SAMHSA, 2015)

Some TIC Initial Drug Court Questions for your Cases

- ***EXAMPLES OF SAFETY, CHOICE, TRUST-INDUCING, EMPOWERING & COLLABORATIVE QUESTIONS***
  - What information would be helpful for us to know about what happened to you? your child? your family?
  - Where/when would you like us to call you? (& THEN act on this throughout your Team)
  - How would you like to be addressed?
  - Of the services I've described, which seem to match your present concerns and needs? Prioritize these along with Drug Court services.
  - From your experience, what responses from others appear to work best when you feel overwhelmed by your emotions?

Creating Cultures of TIC

- Creating Cultures of Trauma-Informed Care: An Agency Self-Assessment and Planning Protocol
- Can Help Families Use this Approach at Home!
- **5 guiding Principles of Trauma-informed practice:**
  - **Safety**
  - **Trustworthiness**
  - **Choice**
  - **Collaboration**
  - **Empowerment**

Court Personnel
Self-Care Rationale

We sometimes carry the expectation that we will give to others before attending to our own needs

This is ultimately self-defeating

Drug Court Teams will function optimally overall by being ***intentional and proactive about finding time to create a culture of caring for each other in the workplace and promoting individual self-care***

Vicarious Traumatization & Secondary PTSD

- Can occur in anyone with sufficient exposure
- Those with less training are more at risk
- Preventive strategies:
  - Get supervision, talk with a work-buddy, seek support from talk spiritual leader, peers, friends, etc.
  - Maintain boundaries, practice professional compartmentalization
  - **Practice Good Self-Care Habits**

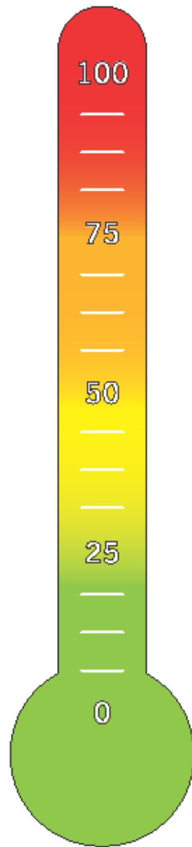
Prepare to Take Care

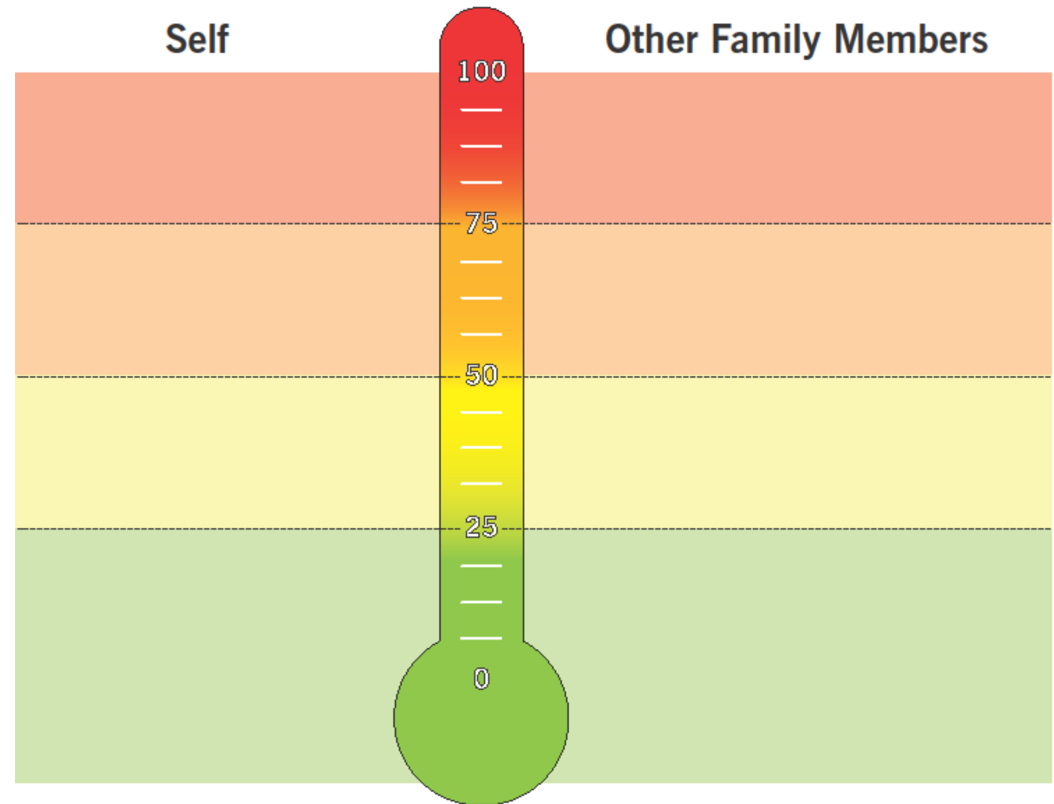
Self Assess for Stress. Periodically (at least annually) assess and realign goals, skills, work, and play passions. Notice disparities and take steps to correct your course!

Evaluate: check a typical week's schedule, prioritize tasks & reduce/eliminate non-essential tasks!
Do **quarterly "Check ins"** to increase likelihood of early recognition of being out of balance, so support & remedies can be mobilized!

Emotional Regulation Skills

Feeling Thermometer





UCLA FOCUS Project

Stress Continuum: Four Stress Zones

READY	REACTING	INJURED	ILL
• Adaptive coping • Effective functioning • Health and well being • The goal of resilience efforts	• Mild and transient distress or loss of function • Very common • Self correcting • Persistence may lead to stress injury	• More severe and persistent distress or loss of function • Less common • Heals better with attention or care • Persistence may lead to illness	• Diagnosable mental disorders • DSM-IV criteria • May follow unhealed stress injury • Quite Rare • Needs treatment

Consider establishing explicit guidance to limit traumatogenic communication

- What is traumatogenic communication?

  - Verbal Sharing that provides images, details, descriptions of traumatic event coupled with one's response

  - Communication that creates an unnecessary trauma exposure to another person

Cosic, K., et al.,

Be Mindful of Traumatogenic Communication

- Appropriate setting for this is in professional therapeutic relationship
- Communication without gory details of trauma can be equally effective
- What kind of guidelines do you already have in place for this?
- How do you manage this now?

Characteristics of Resilient People

- View change or stress as a challenge/opportunity
- Commitment
- Recognition of limits to control
- Engaging the support of others
- Personal or collective goals
- Self-efficacy
- Past successes in coping well with stress
- Faith
- Realistic sense of control/having choices
- Sense of humor
- Action oriented approach
- Patience
- Tolerance of negative affect
- Adaptability to change
- Optimism

Connor & Davidson, 2003 – table 7

PAY ATTENTION to Healthy Eating

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