**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 |
| 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 |
| 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 |
| 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 |
| 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)*)*