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Understanding Trauma: From Theory to Practice

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Positive Approaches Foreword

"In essence, Positive Approaches is a worldview, in which all individuals are treated with dignity and respect, in which all are entitled to Everyday Lives."

−Beth Barol, 1996

The first issue of the *Positive Approaches Journal* was published in summer 1996 and focused on four domains: environment, communication, assessment, and "hanging in there." In the 28 years since that first edition, we have rebalanced our human services system so that most people are served in community versus facility settings. During this time, we have also witnessed significant advances in our understanding of trauma, brain development, genetics, and treatment options. In spite of these advances, the lessons from that first edition of the journal still hold relevance for us today because, as a system, we still face challenges in supporting people with co-occurring intellectual or developmental disability and a serious mental illness to live Everyday Lives.

As our service systems continue to move away from institutional and congregate care and toward supporting people to be fully engaged in their communities, the need to revive the *Positive Approaches Journal* became clear to us. People who have dual diagnoses face some of the greatest challenges for true inclusion and being connected with their communities. We need to work together to develop best practices and appropriate services and supports. The *Positive Approaches Journal* is part of a broad effort to build this capacity and support best practice in service delivery for people with dual diagnoses. The *Journal* will also allow us to share, communicate and collaborate as we address this very important issue.

We are eager for the submissions that will come from practitioners and theorists here in Pennsylvania that will drive innovation at all levels in our service systems. It is truly very exciting to begin publishing the *Positive Approaches Journal* again, and it is with great pleasure that we present to you Volume 13, Issue 1.

Kristin Ahrens
Deputy Secretary
Office of Developmental Programs

Jennifer Smith
Deputy Secretary
Office of Mental Health and Substance Abuse Services

***Positive Approaches Journal* Mission Statement**

To improve lives by increasing capacity to provide supports and services to individuals with mental health and behavioral challenges, intellectual disabilities, autism, and other developmental disabilities, using the guiding principles of Everyday Lives and the Recovery Movement.

Through case studies, articles, interviews, and related academic sources, *Positive Approaches Journal* will strive to feature resources, observations, and advancements that are relevant and timely to professionals and supporters.

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Introduction

A person's experiences and the trauma that lingers can have a significant impact on their health and quality of life. The Shapiro Administration recognized Trauma and Mental Health Awareness Month in May, and we are committed to working year-round to support access to trauma-informed and healing-centered approaches, so Pennsylvania can better respond to the communities we serve and peoples' unique needs.

The Pennsylvania (PA) Department of Human Services (DHS) provides services to care and support some of Pennsylvania's most vulnerable individuals and families every day. As Secretary of DHS, I am committed to continue the department's critical work to help Pennsylvanians lead safe, healthy, and productive lives through trauma-informed services. This is foundational to helping people lead healthy, vibrant lives where they are able to pursue and succeed at their goals.

This issue of the Positive Approaches Journal addresses the approach to trauma and its role in the lives of individuals with intellectual disabilities and autism (ID/A) and mental illness from a variety of perspectives. Just as trauma arises from a variety of sources and experiences, addressing it in a meaningful, accessible way requires that each voice is heard, valued, and respected. There is not, and likely will never be, a simple and uniform approach to broadly meeting the needs of many. We all bring unique experiences and circumstances that shape our present needs, and we must be nimble to effectively meet a person's needs. There are foundational principles that are vital in determining the best path forward in a trauma-informed manner, and we can and should learn from and leverage these principles and best practices. The goal of this issue of the Positive Approaches Journal is to present diverse, expert voices in

understanding trauma from theory to practice. Pennsylvania is increasingly focused on trauma and trauma support, including areas of prevention, recognition, mitigation, treatment, and opportunities for recovery. We encourage all providers and professionals supporting the most vulnerable population to take advantage of several initiatives happening right now, including:

- **TRAIN**- Individuals with intellectual disabilities or autism are at an increased risk of experiencing trauma, however, few therapists are skilled in both trauma and ID/A support. To bridge this gap, psychologists with the Autism Services, Education, Resources and Training (ASERT) team created the TRAIN program – 12 weeks of self-guided learnings and live webinars to equip therapists across Pennsylvania currently working with the ID/A populations, with the skills to support clients through trauma experiences. For more information and to complete the TRAIN Interest Survey, Click here.
- **Eye Movement Desensitization and Reprocessing (EMDR)**- All eligible Medicaid mental health providers are encouraged to apply for the EMDR certification. The partnership with the University of Pittsburgh aims to offer certifications for an innovative EMDR therapy, which will help mental health providers to implement tools to help Pennsylvanians struggling with mental health. The continued implementation of trauma-informed therapies to promote and support the well-being of all Pennsylvanians who need them, remains a priority for DHS. For more information and to register, Click here.

Val Arkoosh, MD, MPH
Secretary of Human Services

Data Discoveries

Trauma can be described as a response to a circumstance, event, or series of events that an individual experienced as stressful, frightening, or physically or emotionally distressing.[1] People may experience these events themselves or they may witness them happening to others. These circumstances can present coping challenges.[2] Trauma can happen in response to serious injuries or violence, and it can affect individuals, families, groups, communities, and generations. Trauma can occur because of natural disasters (e.g., storms and earthquakes) or it can be caused by other people (e.g., war, violence, accidents). Some people feel the effects of trauma immediately while others do not feel the effects for days, weeks, or months. Trauma can affect both physical and mental health.

Trauma can be caused by a single event, repeated events, or sustained and chronic events and can cause emotional, physical, cognitive, behavioral, social, and developmental reactions. Most of these are normal responses to trauma, and very few meet the criteria for mood and anxiety disorders.[2] Trauma can cause emotional symptoms such as increased anger, anxiety, and sadness, and physical responses like sleep, gastrointestinal, and cardiovascular issues.[2] Individuals who have experienced trauma may also engage in self-injurious and compulsive behaviors or attempt to self-medicate with alcohol or other substances to cope with their trauma.[2] Depression and avoidance (avoiding memories, thoughts, or feelings associated with trauma) are also common in individuals who have experienced trauma.[2]

From a data perspective, trauma is difficult to measure because people experience it so differently and most studies have sought to understand types of trauma more qualitatively.[3] While data are limited, autistic people may be more likely to experience potentially traumatic events

(PTE) and to develop Post Traumatic Stress Disorder (PTSD) compared to individuals without autism.[4,5] Preliminary findings suggest that trauma-related disorders may be more common in autistic people compared to non-autistic people.[5] However, more research is needed to understand the prevalence of traumatic stress and PTSD in this population. Nearly 45% of autistic individuals have "probable PTSD symptoms," which is 10 times higher than those without autism.[7] Autistic people may experience sensory differences, which may make it more difficult to cope with stressors. Additionally, there is evidence that people with intellectual and developmental disabilities (IDD) have greater difficulty reporting traumatic events, and their symptoms may present differently compared to people without IDD.[8,9] These differences emphasize the importance of trauma screening for autistic people, and for the development of assessments that consider autistic characteristics.

Research suggesting a higher prevalence of trauma among autistic individuals underscores the importance of trauma-informed care and resilience-building. Identifying PTSD and trauma-related symptoms among individuals with IDD can be challenging for providers. There is an urgent need for multidimensional and individualized assessments to support providers in recognizing PTSD and other trauma-related symptoms in individuals with IDD.

Understanding trauma and building resilience skills are critical first steps in developing a supportive service system for the IDD population. The ASERT resource dashboard below provides key resources for providers, individuals, families, and communities.

Link to Data Discoveries Dashboard

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The Importance of Place in Trauma-Informed Care: A Wellness Approach

John Thvedt & Christine Martin

Abstract

This article delves into the synergy between trauma-informed care and positive supports, framed within a wellness perspective. Trauma-informed care emphasizes creating healing environments, while positive supports focus on strengths and resilience. By merging these approaches, practitioners can bolster interventions for trauma-affected individuals. Key principles and strategies for implementing a wellness-oriented approach to trauma-informed care are discussed, emphasizing collaboration, empowerment, and self-care for both providers and recipients.

Keywords: *Trauma-informed care, positive supports, wellness, empowerment, collaboration, self-care, mindfulness, polyvagal theory.*

Introduction

Temple Grandin has expressed how emotions tie to specific places, highlighting the significant impact of environments on individuals, especially those with autism and/or individuals with intellectual and developmental disabilities (IDD). Most of us have fond memories of happy times in a positive environment. Difficult events are also remembered as a picture of the place and time. People, places, and things create our life stories. Whether places are remembered with happy or sad associations, they generally do not impact our daily lives. However, for the significant number of individuals with autism and/or IDD who have a trauma history, the physical environment can significantly impact their reactions, motivations, and fears, causing acting out behavior. These incidents often lead the individual and those who support and care for them into confusion and despair.

Throughout the history of the human service system in our efforts to help, the place of service and the environment has been a significant factor. When we sought to treat and to protect people with disabilities, they were placed in an institution. When we believed that we needed to train people in production, workshops were created. As we learned more, we embraced the concepts of normalization, inclusion, and individual rights, as community living arrangements were developed. As we now begin to understand the significant impact of trauma on people's lives, and the crisis in our workforce and communities, we should consider the need to create inclusive environments that will support peace and reduce potential triggers or conditions that may cause re-traumatization.

Trauma victims experience triggering memories in certain places, leading to disruptive behaviors. While Functional Behavior Analysis (FBA) dominates as best practice for autism and IDD, the analysis becomes more complex when seeking to understand the problematic behavior

of an individual who has experienced trauma. We need to acknowledge that a behavior that is a function of post-traumatic stress may serve NO useful function (other than survival) for the person. It may be a visceral reaction based on an altered stress-response system, leading to dysregulation of processes such as heart rate variability, digestion, and immune function (Dale, et.al. 2022).

When teaching individuals replacement skills to manage triggered responses, wellness and mindfulness approaches have emerged as complementary, strength-based, positive supports. The concept of "Setting Events," frequently used in behavioral psychology, refers to situational factors that can influence behavior. People can be triggered by places, sounds, and odors. These associations with environments often trigger a "flight or fight" response. As we look to support people who have experienced so much trauma in their lives, it is vitally important that we create environments where setting events are identified and addressed/reduced as much as possible.

Polyvagal Theory emphasizes the physiological aspect of trauma healing, suggesting that safety cues are pivotal in mitigating trauma's impact. Safety, in this context, isn't just the absence of threat, but encompasses a sense of safety detected through positive social cues. Additionally, the theory underscores how trauma alters physiological responses, emphasizing the importance of creating safe, supportive environments.

Mindfulness-based practices represent a promising approach for addressing aggressive and destructive behaviors in individuals with an intellectual disability and autism (ID/A). These interventions not only reduce challenging behaviors, but also significantly enhance the quality of life, offering a holistic alternative to traditional treatments. Mindfulness and acceptance training programs can significantly improve the quality of life for individuals with developmental

disabilities and their families (Hastings, R., & Manikam, R. 2013). Mindfulness is "the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally, to the unfolding of experience moment by moment" (Kabat-Zinn,2003).

Resilience, vital in navigating life's challenges, is nurtured through wellness practices. Acknowledgement that supporters may have a trauma history is important when attempting to "support the supporters." Direct care providers need resources to prioritize self-care so that they can maintain the quality of service they provide. Trauma informed care includes the need for shared wellness for all stakeholders.

Ultimately, the goal of supporting individuals with ID/A is to enhance their well-being while recognizing and addressing the impact of trauma on both individuals and supporters. This approach emphasizes understanding environmental factors and psychological dynamics for all involved parties. Shared Wellness is an example of how person, place, and relationships are served, resulting from the practical integration of trauma informed care, behavior analysis, mindfulness, and polyvagal theory. Shared Wellness, a project under the umbrella of Shared Support South (SSS), is located in Hatfield, Montgomery County. Shared Wellness provides essential services to individuals with intellectual disabilities (ID) and extends its reach to various community populations facing challenges.

Principles of a Wellness-Oriented Approach to Trauma-Informed Care:

The core principles included in the Shared Wellness philosophy include:

1. **Safety and Trustworthiness:**
   - Trauma-informed care emphasizes the creation of safe and trustworthy environments where individuals feel physically and emotionally secure. Trust is

built through honesty and transparency between individuals, supporters, families, and stakeholders.

2. **Self-Care and Self-Regulation:**
    - Meaningful social connections and predictable environments aid in self-regulation, crucial for trauma survivors.
3. **Empowerment:**
    - Recognizing individuals as experts in their experiences, fostering autonomy, and cultivating meaningful relationships.
4. **Collaboration:**
    - Effective care requires collaboration among individuals, families, communities, and service providers.
5. **Holistic Wellness:**
    - Addressing physical, emotional, social, and spiritual well-being comprehensively.
6. **Mindfulness:**
    - Providing present oriented activities, events, and thoughtful interaction.
7. **Peer Support:**
    - Providing opportunities, peer support, and mutual self-care.
8. **Historic Issues:**
    - Addressing and acknowledging historical trauma regarding gender, race, culture, sexual orientation, ethnicity, age, ability, etc.

Strategies for Implementation:

The center is dedicated to wellness approaches that can have a transformative impact on trauma-informed care by providing a supportive environment that prioritizes healing, resilience, and

holistic well-being. Shared Wellness serves as a safe and empowering space where individuals affected by trauma can access comprehensive services and supports tailored to their unique needs.

1. **Safe and Supportive Environment:**
    - The physical design and atmosphere of the wellness center plays a critical role in promoting feelings of safety, comfort, and trust among individuals who have experienced trauma. By creating welcoming spaces that emphasize peaceful colors, soothing sounds, and other pleasing sensory enhancements, the center can help mitigate potential triggers and promote a sense of security for those seeking care.
    - Safety and trust are also important. Trauma-informed care emphasizes the creation of safe and trustworthy environments where individuals feel physically and emotionally secure. Polyvagal theory emphasizes the importance of creating acoustically soothing environments and activities. Shared Wellness provides many opportunities such as humming, playing Tibetan bowls, and soundtracks of peaceful music.
    - The tranquil spa-like environment, set within 12 acres of beautiful, wooded surroundings, fields, and a pond, serves as the backdrop for our mission to promote well-being, mindfulness, and self-care for those we serve and for those who provide the services.
2. **Integrated Services:**
    - Shared Wellness places an emphasis on the bio-psycho-social treatment approach through the coordination of services that address the multifaceted needs of individuals affected by trauma. These services include mental health counseling, nursing care, substance abuse treatment, and peer-led activities. To enhance

collaboration with behavioral health resources, SSS has formed partnerships with psychiatric providers for on-site treatment at Shared Wellness. This approach encourages collaboration and positive associations for the individual in a comfortable, supportive environment. Mindfulness strategies are integrated into therapy and medication management sessions.

3. **Strengths-Based Approach:**
    - Shared Wellness embraces a strengths-based approach that honors individuals' resilience, coping strategies, and personal strengths. Rather than focusing solely on deficits and pathology, trauma-informed care within the context of Shared Wellness emphasizes individuals' assets, resources, and capacity for growth and recovery. This approach promotes empowerment, self-efficacy, and collaboration, enabling individuals to actively participate in their healing journey.
4. **Community Engagement and Peer Support:**
    - Shared Wellness serves as a hub for community engagement and peer support, offering opportunities for social connection, mutual aid, and collective healing. By fostering a sense of belonging and solidarity among individuals affected by trauma, one can combat feelings of isolation and promote social connectedness, resilience, and recovery. Also, this provides individuals with ID/A support to expand their connections and relationships into their communities.
5. **Holistic Wellness Programming:**
    - In addition to traditional clinical services, Shared Wellness offers a variety of holistic wellness programming that addresses the physical, emotional, social, and spiritual dimensions of well-being. This may include mindfulness practices, yoga,

art therapy, nutrition education, and stress management workshops, among other activities. By incorporating holistic approaches to wellness, the center can support individuals in cultivating self-care practices and coping skills that promote overall health and resilience.

An example schedule for an individual would be the following:

- **10:00 AM - 10:30 AM:** Mindfulness meditation (e.g., sound, guided, breathwork, etc.), followed by juice made by the participants.
- **10:30 AM - 11:00 AM:** A group on social skills, nutrition, art, movement, or physical activity.
- **11:00 AM - 1:00 PM:** Community advocacy, Shared Kindness Projects, and Individual Volunteerism.
- **1:00 PM - 4:00 PM:** 1:1 mindfulness coaching, sensory experiences, therapy, and behavior support (e.g., reinforcement for engaging, or prompting). Individuals also have access to the center's resources such as meditation rooms, sound baths, and massage chairs.

6. **Trauma-Informed Practices:**

- Integrate trauma-informed practices into all aspects of service delivery, including screening, assessment, intervention, and evaluation. These practices prioritize safety, trustworthiness, choice, and collaboration while minimizing the risk of re-traumatization.

7. **Positive Supports:**

   - Incorporate positive supports, such as strengths-based case management, peer support, and community engagement into interventions, to enhance individuals' sense of belonging, agency, and social connectedness.

8. **Self-Care for Individuals and Providers:**

   - Recognize the importance of self-care for both individuals and providers and then incorporate strategies to promote resilience, stress management, and work-life balance. Shared Wellness provides Yoga and sound and breath work for all employees free of charge during varying hours throughout the day. By prioritizing their own self-care, providers can better support and model their well-being to those they serve, to truly experience Shared Wellness.

Conclusion

A wellness-oriented approach to trauma-informed care, within the context of positive supports, offers a holistic and empowering framework for promoting healing, resilience, and well-being among individuals affected by trauma. By integrating principles of empowerment, collaboration, and self-care, practitioners can enhance the effectiveness and sustainability of interventions, while honoring individuals' strengths, dignity, and inherent capacity for growth and recovery. Moving forward, continued research, training, and implementation efforts are needed to advance this approach and ensure that all individuals have access to trauma-informed care that supports their holistic wellness and flourishment.

Setting events are places and/or inner spaces deeply embedded within cultural contexts, shaped by norms, values, and beliefs, that influence individuals' experiences and responses to trauma.

Culturally competent trauma-informed care acknowledges the diversity of settings and recognizes the impact of culture on individuals' coping mechanisms, help-seeking behaviors, and healing practices.

Incorporating these places into trauma-informed care requires practitioners to adopt a comprehensive approach that considers the physical, social, and cultural dimensions of individuals' environments. This may involve conducting thorough assessments, collaborating with individuals to identify triggers and coping strategies, and creating supportive environments that prioritize safety, trust, and empowerment. By addressing setting events (i.e., places and/or inner spaces) within the context of trauma-informed care, practitioners can enhance the effectiveness and relevance of interventions, ultimately promoting healing, resilience, and holistic well-being for individuals affected by trauma, to improve their everyday lives.

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Biographies

John Thvedt, Psychologist/CEO, Shared Support South, has over 40 years as a licensed psychologist in the Intellectual and Developmental Disabilities (IDD) field, John Thvedt has served as clinical director, behavior specialist, therapist, consultant and CEO for non-profit organizations across the US. He is the original co-founder of Shared Support Concepts, subsequently, Shared Support Inc., and currently, Shared Support South. In his career John has run group homes for the Jay Nolan Center for Autism as part of the de institutionalization movement in California in the early 80's; provided behavior specialist services throughout southern California; consulted on the Southern Poverty law center's review of state hospitals in Florida; and conducted mandated annual reviews of Pennhurst individual's services following their return to community living after the closure of the institution. Currently, John is dedicated to trauma informed program design that supports the clinical and everyday life needs of people with complex behavioral health needs and IDD through Shared Support South.

Christine Martin, President, Shared Support South, has 38 years of experience in the Intellectual and Developmental Disabilities (IDD) field, Chris Martin has held various roles spanning Direct Support, Management, and Executive positions. She is the original co-founder of Shared Support Concepts, subsequently establishing Shared Support Inc., and currently presides over Shared Support South. Throughout her career, Chris has directed Supports Coordination units and served as the Executive Director for the Arc of Bucks County, where she spearheaded grant initiatives aimed at enhancing mental health services for individuals with IDD. In her role as a consultant, Chris has coordinated and led Self-Determination initiatives across several Pennsylvania counties and Maryland. Chris has also supported teams to plan for individuals with a dual diagnosis transitioning from institutional settings into community living. Currently, Chris is dedicated to trauma informed program design that supports the clinical and everyday life needs of people with complex behavioral health needs and IDD through Shared Support South.

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Understanding Complexity: The Convergence of Disability and Trauma in Clinical Practice

Jessica S. Reinhardt & Aidan Campagnolio

The incidence of trauma has seen a notable rise across both the general populace and among those with disabilities. This paper is rooted in an understanding of the concurrent presence of disabilities and trauma, aiming to enhance practitioners' work. This overview provides practitioners with concise guidelines on diagnosing trauma, implementing trauma-informed care, and selecting trauma-specific treatments appropriate for individuals with disabilities. It is important to note, however, that a comprehensive review of these complex and interwoven topics is beyond the scope of this paper. Nonetheless, we highlight the critical need for more extensive research to further our understanding and to guide the development of more evidence-based interventions in this area.

Individuals with intellectual disabilities (IDD) are more vulnerable to psychological trauma compared with the general population [1] . Similarly, research indicates that children diagnosed with IDD[2] and autism spectrum disorders[3] (ASD) are more susceptible to repeated instances of maltreatment, including bullying, abuse, and sexual assault. Exploring the intersection of various disabilities and trauma/trauma-related disorders such as Post-Traumatic Stress Disorder (PTSD), presents a significant challenge for professionals in selecting the most suitable clinical intervention strategies. Mehtar and Mukaddes [4] found that there was a 26% overlap in the incidence of autism and potentially traumatic experiences, with 17% of the individuals fulfilling the diagnostic criteria for both PTSD and autism. That said, differentiating between symptoms of trauma, and IDD and/or ASD, presents a challenge to clinicians, as there are several shared characteristics between autism/IDD and PTSD, and other stressor related disorders [5 6] . Research suggests that those who reported experiencing traumatic life events, in both child and adulthood,

had a significantly higher risk of aggression, self-injurious behavior, in addition to symptoms of psychological distress [7]. Problematic and aggressive behaviors in individuals with IDD are thought to be mediated by past traumatic experiences and mental health [8 9]. The overlap or mediation of externalizing symptoms of trauma, internalizing symptoms are difficult to distinguish. More specifically, Kildahl and colleagues [10] found that altered arousal was easily observable, but symptoms of avoidance present differently, and symptoms of re-experiencing were difficult to recognize (unless the clinician knew of the person's trauma). Challenges with diagnosis are likely exacerbated by the lack of instrument designed specifically for populations with disabilities. Of note, the recently published Diagnostic Interview Trauma and Stressors – Intellectual Disability (DITS–ID), has shown promising psychometrics [11]. Given the multifaceted challenges inherent in accurately diagnosing trauma within populations with disabilities, it becomes imperative to pivot focus towards developing an understanding of trauma-informed care and interventions that are specifically designed to address the unique needs of these individuals.

Trauma-Informed Approaches (TIA) and trauma-specific treatments are two complementary, yet distinct approaches in mental health care. TIA is an organizational framework that pervades the policies, practices, and culture of an institution. A key underlying belief guides TIA: any individual may have experienced trauma at some point in their lives. Thus, TIA aims to minimize re-traumatization, promote safety, and support healing by adjusting the overall environment and interactions. TIA does not directly treat trauma but creates a supportive setting that acknowledges the prevalence and impact of trauma on individuals' lives. Substance Abuse and Mental Health Services Administration's (SAMSHA) guidance around TIA speaks of the four Rs, namely: [12]

1. **Realize** the profound and pervasive consequences of trauma, acknowledging the pathways toward recuperation and resilience for individuals, as well as the collective within communities, organizations, and beyond.
2. **Recognize** the signs and symptoms of trauma, which may vary across gender, age, and setting, in everyone from service recipients to staff members, fostering an environment where these signs are understood as survival mechanisms in response to past or current adversities.
3. **Respond** by infusing the principles of a trauma-informed approach throughout the entire organizational structure, altering language, behavior, and policies to honor the traumatic experiences of both service users and providers, and embedding this understanding into the fabric of organizational culture.
4. **Resist** re-traumatization by consciously creating a safe, supportive environment that avoids replicating the dynamics of trauma, ensuring that the organization's practices promote recovery and do not inadvertently contribute to stress or trauma.

To achieve these, SAMSHA's model is centered around six key principles summarized below[12][13].

1. **Safety**: Ensuring physical and emotional safety for all in a space (clients and staff.) This involves creating spaces and interactions that foster a sense of security, reducing potential stimuli that can lead to re-traumatization.
2. **Trustworthiness and Transparency**: Building trust with clients through consistent, transparent practices and policies. This principle emphasizes the importance of clarity, integrity, and openness in operations and interactions, helping clients to rebuild trust in systems and individuals.

3. **Peer Support**: Recognizing the critical role that peer support plays in recovery and healing. This principle champions the inclusion of individuals with lived experiences of trauma in the healing process, providing mutual support and shared learning opportunities.
4. **Collaboration and Mutuality**: Promoting equality and democratization in the therapeutic relationship. This involves breaking down hierarchical dynamics between professionals and clients, fostering a more collaborative and participatory approach to care and decision-making.
5. **Empowerment, Voice, and Choice**: Empowering clients by prioritizing their voices and choices throughout their care. This principle stresses the importance of highlighting individuals' strengths, ensuring that clients have a say in their treatment plans, and are supported in their recovery journey.
6. **Cultural, Historical, and Gender Issues**: Acknowledging the impact of cultural, historical, and gender issues on trauma and recovery. This principle requires an awareness and responsiveness to the diverse experiences of trauma among different populations, incorporating practices that are respectful of and relevant to individuals' cultural, historical, and gender identities.

The present authors argue that cultural, historical and gender issues should not be treated as a separate principle. Rather we advocate that attunement to cultural context is a critical overarching concept which informs the other five principles in trauma informed care. Readers interested in adopting a trauma-informed framework are encouraged to view: SAMSHA's Practical Guide for Implementing and Trauma-Informed Approach. [13]

Many different fields have begun adopting TIA, including, but not limited to, education, counseling, nursing, social work, and yoga. In addition to systemic TIA , there is a great need for trauma-specific treatments designed for individuals with disabilities. A dual approach using both TIA and specific treatments is critical. Trauma-specific treatments refer to research-supported clinical interventions specifically designed to address the consequences of trauma. Examples include: Cognitive Behavioral Therapy (CBT) for PTSD, Eye Movement Desensitization and Reprocessing (EMDR), and trauma-focused cognitive-behavioral therapy (TF-CBT), among others. Individuals with intellectual disabilities, autism, and other developmental disabilities, are often lacking in trauma-specific treatment research. Specifically, there is a gap in the current literature containing randomized, controlled trails (RCTs) to further support the effectiveness of many treatment modalities [16] . That said, the early stages of research show promise.

A recent systematic review investigates the literature on EMDR and CBT interventions for children and adults with an intellectual disability presenting with PTSD or trauma-like symptoms[16] . EMDR has capacity for producing meaningful therapeutic outcomes in adults with ID [14, 15, 16]. There is specific support for EMDR as a useful and effective intervention for people with ID, noting EMDR's applicability with non-speaking clients and its efficient treatment timeline compared to alternatives[16]. CBT informed treatments and TF-CBT also show promising evidence, although the research has been limited [16] . While it is recognized that considerable methodological limitations persist in much of the current research, these studies nevertheless offer practitioners a foundation of hope. This research paves the way for more inclusive and effective therapeutic interventions. Indeed, it is essential to tailor these methodologies to the nuanced needs of individuals with disabilities. The burgeoning body of early-stage research offers a beacon of hope, illuminating the path toward a future where all individuals, irrespective

of their abilities, receive the compassionate and specialized care they deserve for trauma recovery.

In synthesizing the literature on trauma within populations with disabilities, the imperative becomes clear: We must continue to evolve our clinical practices to better understand and address the complex layers of trauma experienced by individuals with disabilities. The convergence of trauma-informed approaches and trauma-specific interventions offers a promising horizon for practitioners. Advancing this dual approach will not only deepen our grasp of trauma's multifaceted nature, but also enhance the healing and empowerment of those who have been historically marginalized in our health care narratives.

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A Review of Top-Down and Bottom-Up Trauma Interventions

Julie Vayner & Kate Jakubovic

Abstract

The objective of this article is to review literature and modalities pertaining to positive approaches in treating trauma and posttraumatic stress disorder, with the use of expressive interventions in individuals with intellectual disabilities and/or mental health and behavioral challenges.

Key Words: *Posttraumatic stress disorder, trauma therapy, expressive therapy, top-down, bottom-up, cognitive, behavioral, somatic, mind-body connection*.

It is not known exactly how much of the population has been exposed to a traumatic event, but it is estimated that most people in the United States will be exposed to at least one traumatic event in their lifetime.[1] While there is a specific set of criteria of symptoms one must endorse to be diagnosed with post-traumatic stress disorder (PTSD), the lasting effects of trauma can manifest in a variety of ways that may not be exclusive to PTSD. The effects of traumatic stress on the brain and physical body have been researched for over forty years. There is an increased understanding that traumatic experiences can cause short-term and long-term effects on various organs and systems in the body, due to the disruption in homeostasis.[2] As a result, interventions used to treat post-traumatic distress should consider adopting a holistic approach to target cognitive, behavioral, emotional, and physiological processes. It may be useful to combine elements from both, top-down (cognitive) and bottom-up (physiological) approaches based on the client's individual needs. This literature review explores several top-down and bottom-up therapeutic interventions targeting post-traumatic distress.

Trauma therapies tend to fall into two very distinct categories: top-down or bottom-up. Top-down approaches include traditional talk-based, cognitive, and behavioral therapies. This approach works to resolve symptoms by working with the area of the brain known as the neocortex. The neocortex is responsible for logic and reason. Alternatively, bottom-up approaches, such as expressive and somatic ones, target the limbic system of the brain. This part of the brain focuses on feelings, automatic reflexes, and sensory receptors that run throughout the body. Both therapies have strengths, and therefore holistic approaches that include both, help better facilitate a mind-body connection, resolve unprocessed memories, and move the individual from a state of stress response to stabilization. Additionally, stages of trauma recovery typically

involve three phases that include, 1) Safety and stabilization, 2) Remembering, mourning, and grieving, and 3) Integration and connection.[3]

To facilitate these phases, a diverse array of evidence-based modalities, which include expressive components, can be deployed. Both top-down and bottom-up approaches will be examined. Keep in mind, these modalities can be utilized on their own, simultaneously by the same practitioner, or adjectively by another practitioner working with the same client. Considering top-down modalities from Cognitive Behavior Therapy (CBT) developed by Aaron Beck in the 1960s, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) was expanded by Anthony Mannarino, Judith Cohen, and Esther Deblinger in 2006, to assist children and adolescents in recovering from trauma. TF-CBT seen as a short-term (8-25 sessions) option and includes sessions with both the identified client and their caregiver or another trusted individual. The sessions are highly structured and cover psychoeducation, effective parenting skills (relating to the caregiver's personal distress about the client's experience), relaxation skills, affective modulation, cognitive coping and processing, trauma narration, in vivo mastery, conjoint parent-child sessions, and enhancing safety in the client's natural ecology.[4] The primary intervention focuses on trauma narration and processing, which can be assisted through writing, storytelling, drawing, and even music. For example, clients can select songs or music that help express their experiences, which are otherwise difficult to verbalize. It was initially developed to address the needs of children who experienced sexual abuse but has expanded and adapted to treat other populations and age groups across developmental levels and cultures.[5]

Alternatively, prolonged exposure (PE) developed by Edna Foa, Ph.D. in 1991, is another cognitive behavioral or top-down approach, which is based on emotional processing theory, and focuses on assisting clients in emotionally processing their traumatic experience (s). It is

intended to be a short-term intervention consisting of approximately 15, 90-minute sessions. The sessions are also highly structured and involve psychoeducation, breathing retraining, imaginal exposure, cognitive and emotional processing, and homework review. Outside of session, the client practices imaginal exposure as well as in vivo exposure. The intervention targets fear and avoidance by focusing on the client repeatedly exposing themselves to the trauma memory in a variety of ways, until habituation occurs and the memory becomes less distressing. While a person may want to avoid reminders of their trauma and other trauma related stimuli due to the unpleasant feelings they trigger, avoidance serves to maintain post-traumatic distress. Decreasing avoidance through repeated exposure to the trauma memory and emotional processing, allows the client to build tolerance to the trauma related stimuli and experience less distress overall.[6]

Bottom-up approaches include interventions that focus on physiological and somatic processing. Expressive therapies are a group of interventions that target the expression of thoughts and feelings through nonverbal and alternative means of communication. Through this process clients can regain a sense of control. Some examples of expressive therapies may include but are not limited to visual arts therapy, music engagement, movement based creative expression, and expressive writing.[7,8] These approaches are centered around creative arts and are considered non-traditional. Existing research on expressive therapies contains limitations that affect generalizability across populations; however, preliminary research demonstrates that creative and artistic approaches may have an impact on decreasing post-traumatic distress and improving overall physical health.[7,8] Visual arts therapies involve clients using an artistic medium (e.g., painting, drawing, sculpting) to represent their emotions related to the trauma. Music engagement teaches clients to self-regulate through playing musical instruments and form interpersonal connections through playing with others. Movement based creative expression

promotes release of tension and stress through dance and body movement (e.g., yoga). Expressive writing promotes emotional expression using language and creative writing. Due to the limitations in research on expressive therapies, it may not be appropriate to rely exclusively on them as the primary source of trauma treatment. However, employing expressive therapeutic techniques in conjunction with other interventions, can help the client adopt a variety of outlets for emotional expression and coping.

Speaking of bottom-up approaches, Eye Movement Desensitization and Reprocessing (EMDR), established by Francine Shapiro in the 1980s, has become highly popularized in recent years. The goal of this therapy is to target distressing memories, themes, and uncomfortable body sensations while installing more adaptive outlooks utilizing eye movements or bilateral body exercises, such as self-tapping, tactile buzzers, and auditory music. Expressive takes on this modality can also incorporate drumming, coloring/scribbling back and forth, acting/role-playing (psychodrama), walking/marching, and dancing, which is notably useful in addressing preverbal and communication deficit needs.[9] This modality is based on the premise that unhealed traumatic memories become stored maladaptively and lead to maladaptive responses. It is particularly beneficial in reducing risk for flooding and re-traumatization through less intense desensitization practices, wherein the client simply imagines the stimuli versus direct exposure as is conducted with other therapies.[10] EMDR includes an eight-phase protocol, consisting of 1) History taking and treatment formulation, 2) Resourcing, preparation, and coping strategies, which is an ongoing process in the treatment, 3) Assessment, 4) Desensitization, 5) Installation, 6) Body Scan, 7) Closure, and 8) Re-evaluation. Through this process, the client can work on a singular event or cumulating patterns and themes causing them distress.

From EMDR, a more somatic-based approach, Brainspotting, was adapted by David Grand in the early 2000s. It was initially discovered through work pertaining to creativity and performance enhancement, and therefore has been opted for by athletes and artists alike. Brainspotting is used to locate points in the client's visual field to facilitate the accessing of unprocessed trauma in the subcortical region of the brain.[11] This part of the brain targets cognitive, affective, and emotional functioning. When memories aren't properly processed (i.e. moved into long-term storage), they remain stuck in this region. Brain spots can be located in a variety of ways, including the client organically coming upon or the clinician noticing a particular focal point as the client looks about the room (Gazespotting), or the client and clinician working together to detect a spot of activation or grounding in the client's visual field using a pointer. Clients can elect to work on a topic from a brain spot that is more activating or less activating (grounding). This type of approach allows for deeper access and reprocessing. It seeks to connect emotional, mental, and physical responses to trauma and releases stress held in each domain. Another benefit of this approach is that the client does not need to "relive" a traumatic event, which can be especially accommodating for clients with high dissociation.

Holistic approaches to treating post-traumatic distress are gaining popularity as more research emerges supporting the connection between the effects of traumatic stress on the mind and physical body. In this literature review, we highlighted several therapeutic interventions from both top-down and bottom-up approaches. Trauma treatment does not fall into a one size fits all category. It is recommended to consider an individual's strengths and limitations when selecting therapeutic interventions. For instance, a high functioning, neurotypical individual may benefit from cognitive behavioral therapies (top-down) with expressive components, whereas a lower

functioning, neurodivergent individual may benefit from bottom-up approaches, focusing more on expressive and creative means of communicating than cognitive components.[12]

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Biographies

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Key Elements of Trauma-Informed Care and Potential Misconceptions

Gordon R. Hodas, MD and Cären L. Rosser-Morris, PhD

Introduction

This article, intended for agencies and organizations seeking to implement trauma-informed care (TIC) and for others seeking to learn more about it, identifies key elements of TIC and potential misconceptions related to TIC.

What Trauma-Informed Care Involves

Trauma-informed care is a universal public health principle that recognizes the prevalence and potential consequences of trauma and adverse childhood experiences in the population, and it seeks to address these. In mental health and other human services, TIC involves intentional efforts on the part of systems, agencies, and their staff to mitigate the impact of trauma and to prevent re-traumatization. TIC is a growing priority in children's services, and it is relevant to mental health and other human services across the lifespan. The principles of TIC are also relevant in other systems and social contexts.

In 2014, the federal Substance Abuse and Human Services Administration (SAMHSA) identified 6 guiding principles for a trauma-informed approach to care.[1] These principles have been widely adopted and involve the following:

- Safety.
- Trustworthiness and transparency.
- Peer support.
- Collaboration and mutuality.

- Empowerment and choice.
- Cultural, historical, and gender issues.

A central theme is that the above interpersonal elements need to be present in relationships between individuals served and staff providing services. Of equal importance is that these same elements apply to the relationships between agency staff and their organization.

The Growth and Evolution of Trauma-Informed Care

For many reasons, awareness of the pervasiveness and consequences of trauma has increased over the past 35 years, along with greater interest in addressing trauma and preventing it in service settings. Contributing elements included increasing awareness of the potential negative effects of restrictive procedures in mental health, outcomes from the landmark Adverse Childhood Experiences (ACE) Study,[2] and strong advocacy on the part of trauma survivors in support of what came to be known as trauma-informed care.[3]

In 2001, Harris and Fallot identified trauma-informed care, a concept distinct from trauma-specific treatment, as an orientation and commitment to all individuals irrespective of the type of service they might be receiving. [4] In 2009, these individuals highlighted the benefits of an intentional organizational commitment to TIC, which when implemented systematically can lead to a self-sustaining trauma-informed culture. [5]

While the prevention of potential harm in care remains a TIC priority, TIC now also involves efforts to promote positive practices in treatment and care, which include supporting the autonomy and empowerment of individuals receiving services. In this way, TIC can help mitigate the negative impact of past trauma and also promote growth, resilience, and healing among individuals receiving care.

Key trauma-informed practices include the following:

- Partnering with individuals receiving treatment or services.
- Engaging individuals and encouraging their active participation in care by identifying their concerns, needs, and priorities.
- Identifying and promoting the strengths and capabilities of the individual and the family.
- Using *the trauma lens* to better understand the individual's experience of trauma and adversity, and also learning to recognize the adaptive nature of coping behaviors previously developed in response to unsafe circumstances, even though these behaviors might be viewed as maladaptive in a safer context.
- Promoting skill-building, including self-advocacy, self-care, and pursuit of wellness.

At a policy level, the Commonwealth of Pennsylvania, which has been promoting trauma-informed interventions in behavioral health for many years, made a formal commitment to become a trauma-informed state in 2019.[6] This entails the envisioned attainment of TIC in public institutions and in communities. Within the Office of Mental Health and Substance Abuse Services (OMHSAS), the authors have developed specific tools to help agencies assess and promote a range of trauma-informed practices. These tools are available for use within Pennsylvania at no charge.[7] In addition, OMHSAS has been pursuing a partnership around TIC implementation in Pennsylvania with the five behavioral health managed care organizations that serve Medicaid-enrolled individuals.

Trauma-Informed Care Implementation

The implementation of TIC is not easily achieved and requires an explicit agency commitment, an intentional approach, and persistence. Other important TIC facilitators, as described by Huo

and colleagues (2023)[8] include strong agency leadership, staff engagement, training, allocation of human and financial resources, service-user involvement in design and quality improvement, and collection and use of data. The absence of any of the above elements could undermine an agency's efforts to implement TIC. Effective TIC implementation also involves recognition of common misconceptions related to TIC. Below we identify and consider some of these.

Specific TIC Misconceptions

1. **TIC is incorrectly perceived as applicable only to individuals with a known trauma history**.
    - As a universal public health principle, TIC is applicable to everyone. Universal practices in medicine dictate the use of gloves for medical personnel treating an individual who is bleeding, predicated on the presumption that the individual in question is infectious. Similarly, universal practices in human services presumes that each individual receiving services has had exposure to trauma and adversities, and that this individual will therefore benefit from the provision of TIC. There are many individuals in communities who have been significantly impacted by trauma and adversity, whose trauma history has not been identified or disclosed. In addition, the ongoing risk of traumatization and re-traumatization in care settings further reinforces the need for the provision of TIC for everyone.
2. **TIC is incorrectly equated with the provision of trauma-specific treatment.**
    - As previously discussed, TIC is an intentional approach to treatment and care that is distinct from the provision of trauma-specific interventions, such as Trauma-Focused Cognitive Behavior Therapy (TF-CBT). While clinically

based trauma treatment is indicated for some trauma survivors, TIC constitutes a set of interpersonal principles that is applicable to everyone. For example, all individuals receiving services require safety, and all can benefit from transparency and collaboration.

3. **TIC is incorrectly perceived as an intervention that only trained mental health clinicians can provide.**
    - TIC involves a set of humane and respectful interventions that any committed and properly trained individual can provide. It is not necessary to be a mental health clinician in order to provide care that is trauma-informed. Further, while some individuals might be intuitively trauma-informed in their interactions with others, training, mentoring, and ongoing support in the provision of TIC remain important.
4. **Workforce well-being is inappropriately viewed as primarily the responsibility of individual agency staff members.**
    - TIC principles are applicable to staff both individually and as a workforce. Staff working with trauma survivors are at risk of vicarious trauma and secondary stress. While staff self-care is an important part of staff well-being, agencies also have a responsibility to help maintain well-being within their workforce. Agencies need to demonstrate that they value and appreciate their staff and provide them with appropriate support and training. Agencies also need to actively address issues of staff's well-being and wellness with staff directly, rather than simply providing information about wellness apps and/or the Employee Assistance Program (EAP). Supervisors in particular can help

staff address work-related challenges and the maintenance of appropriate work-life balance.

5. **TIC is incorrectly perceived as being unconcerned with individual responsibility and accountability for trauma survivors.**
    - TIC actively uses a trauma lens and considers the question of *what happened to you* rather than *what is wrong with you*. However, this focus in no way diminishes the importance of individual responsibility and accountability on the part of the individual. Skill-building and empowerment are key elements of TIC. In fact, by experiencing a greater sense of personal agency resulting from the provision of a trauma-informed approach that places value on personal voice and choice, the individual becomes better able to be responsible and accountable and to identify personally meaningful, prosocial goals.
6. **TIC is incorrectly seen as being achievable through discrete trainings alone, rather than through an ongoing organizational commitment and the maintenance of a trauma-informed culture.**
    - There are no shortcuts for an agency seeking to provide TIC. Trainings are essential, but they need to be ongoing rather than once-and-done. The agency's commitment to TIC needs to be formal and explicit. Agency policies and procedures are reviewed and modified as indicated, so that they are consistent with trauma-informed practice. A trauma-informed culture is supported through respectful interactions, trauma-informed supervision,

meetings that support safe and open discussion, and regular review of progress and ongoing challenges related to the effective provision of TIC.

Conclusion

Current efforts to provide TIC and to create TIC systems build on decades of advocacy and the efforts of trauma-survivors, community advocates, and professionals concerned with the well-being of those impacted by trauma. Trauma-informed care involves an intentional effort on the part of health and human service agencies, public institutions, and their staff to recognize and address the widespread impact of trauma in the population, while also working to prevent trauma and re-traumatization in care provision.

Organizations seeking to provide effective trauma-informed care need to recognize the long-term nature of this commitment in order to build on current resources and address potential barriers. One kind of barrier discussed in this article involves potential misconceptions related to TIC. Building on a genuine understanding of what TIC is and what it can offer, we encourage human service agencies and other organizations to engage in self-assessment in order to identify both their strengths and their opportunities for improvement. These efforts can facilitate effective TIC implementation and the desired attainment of a trauma-informed culture.

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Biographies

Gordon R. Hodas, MD, is a Board-Certified Adult and Child Psychiatrist, who has been a policy consultant for the PA Children's Bureau and the PA Office of Mental Health and Substance Abuse Services (OMHSAS) since 1992. He received his medical degree from the Pearlman School of Medicine at the University of Pennsylvania. His residency in Adult and Child Psychiatry was at Boston University Medical Center, and his Child and Adolescent Fellowship at the Philadelphia Child Guidance Clinic. Dr. Hodas is a Distinguished Life Fellow of both the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry. In his role with the Children's Bureau, Dr. Hodas has advocated for trauma-informed care since approximately 1999. In 2006, Dr. Hodas' paper, "Responding to Childhood Trauma: The Promise and Practice of Trauma Informed Care," was published by the National Association of State Mental Health Program Directors (NASMHPD). Currently, Dr. Hodas is helping OMHSAS and the Department of Human Services in its efforts to implement trauma-informed care and related trauma-informed practices.

PA/Train/Interagency Conference/2024 Conference-GRH Short Bio-1-24-24

Cären L. Rosser-Morris, PhD, is a licensed psychologist and consultant for the Pennsylvania Office of Mental Health and Substance Abuse Services since 2016. She earned her doctorate in clinical psychology from Vanderbilt University under the mentorship of Dr. Hans Strupp in 1993 and has since become a subject matter expert on trauma-informed care. For over 30 years, she has provided psychological services to adults, children, youth and families struggling with the impact of trauma on mental and behavioral health in a variety of outpatient, inpatient, residential treatment, and educational settings.

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Bridging Theory to Practice: Trauma Proficient Services for Youth with Autism and Developmental Disabilities

Kimberly Blair, Teri Pentz, Alonzo Alston, and Tara Pavlocak

Children with intellectual and developmental disabilities (IDD) are more likely to experience trauma than neurotypical children. [1] This higher prevalence is due to several risk factors including but not limited to: communication and language barriers, behaviors that can be mistakenly attributed to their disability rather than a traumatic experience, more frequently needing medical procedures or hospitalizations resulting in medical trauma, and the frequent need for multiple caregivers across multiple settings (increasing the risk of trauma from exploitation). [2] They are also more likely to experience bullying and rejection by peers in schools, communities, and on social media. [3]

Despite these individuals being more vulnerable and at higher risk, youth with IDD and their families may find it difficult to obtain trauma treatment. Mental health services and IDD services are typically provided through siloed systems of care, presenting a barrier to receiving trauma-informed care within either system. Additionally, providers in the mental health system are often hesitant to engage in trauma therapy with this population, often lacking the necessary expertise and possibly even being unaware that children with IDD can benefit from this type of care.[3] Existing trauma therapies can be just as effective with children with IDD as it is with children without – by providing good quality, person-centered treatment in a way that appreciates their unique abilities, strengths, hopes, and goals.

The National Child Traumatic Stress Network (NCTSN) provides a wealth of resources for clinicians, service providers, and caregivers on the impact of childhood trauma and available

interventions for children and adolescents who have experienced trauma. For practitioners who need additional resources, information is available about how to adapt existing trauma treatments for children with IDD, as many of these evidence-based treatments can be effective with modifications to standard protocols. These recommendations include the types of adaptations appropriate for all children in various contexts. For example, adaptation may include adjusting the length, frequency, and pace of content in treatment sessions; significantly involving parents and other caregivers into treatment sessions; adjusting content to meet the needs of the child by breaking information into smaller chunks, simplifying information, or engaging in frequent repetition of key concepts; and using accommodations effective for the child in other contexts, such as frequent movement breaks, reinforcers, or rewards. [3] Despite the demonstrated need for access to trauma therapy, families with children who have IDD continue to struggle to find quality care. As described above, there are many reasons why finding trauma-proficient therapists to serve this population can be a challenge.

For decades, young children and families have sought treatment from the Matilda Theiss behavioral health programs at UPMC Western Psychiatric Institute and Clinic (now UPMC Western Psychiatric Hospital). In 2012, the University of Pittsburgh Department of Psychiatry was awarded a federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). With this grant, UPMC and the University of Pittsburgh became part of the National Child Traumatic Stress Network (NCTSN) and implemented evidence-based treatment options through their outpatient program for children and families who have experienced trauma. Since the initial grant (2012-2016), two more rounds of funding were awarded, which allowed the programming to grow and evolve into what is now the Theiss Center for Child and Adolescent Trauma. Over the years, the program has attempted to provide high

quality trauma therapy to all children who have experienced significant trauma and has engaged children with and without intellectual and developmental disabilities.

A Case Example

The following is a case example illustrating how Theiss has successfully provided trauma treatment for a child with autism and comorbid mental health issues.

Levi is a 17-year-old male referred by his residential program to the Theiss Center for Child and Adolescent Trauma at UPMC Western Behavioral Health for outpatient trauma therapy. Levi had a long history of trauma, including the death of his father from community violence and the death of his grandmother due to an overdose – all while he was still a toddler. Levi lived with his biological mother and her boyfriend until seven years of age, where he experienced severe neglect, physical abuse, and suspected sexual abuse. He was removed from this home at age seven and placed with his paternal grandmother. However, he was returned to his biological mother's care several times before being permanently placed with his grandmother at age 11. While living with his grandmother, Levi exhibited extreme physical aggression, rage, and extensive property destruction, resulting in multiple hospital and residential placements throughout his adolescence.

Since the time of referral, Levi has resided within a specialized residential program for children and adolescents with complex needs. Staff members from this program contacted Theiss after attending a virtual training on child trauma, not only referring Levi for therapy, but also seeking additional training and consultation to support him in the residential setting given his extensive trauma history.

Prior to his initial evaluation for services, Levi received a variety of diagnoses including Autism Spectrum Disorder, Intellectual Disability, Disruptive Mood Dysregulation Disorder, Post Traumatic Stress Disorder, Intermittent Explosive Disorder, and Reactive Attachment Disorder. He continued to exhibit rage, physical aggression, and property destruction within this residential placement. This behavior necessitated the need for two staff to accompany him for most of the day. These staff members felt it was unsafe to transport Levi into the community due to aggression and elopement concerns. Staff communicated that Levi wanted to talk about his painful early experiences and that he was requesting the support of a therapist. Therefore, after extensive safety planning, Levi began treatment in-person at the outpatient clinic.

When he began trauma treatment, the initial focus was establishing rapport and providing Levi with a safe space to talk. The therapist focused on ways that Levi could communicate his wants, needs, and feelings without resorting to aggression. The therapist also provided Levi with feeling words and helped him identify nonverbal signals that he could utilize to label what he was feeling. They also worked on identifying Levi's triggers and helping him connect these feelings with his past trauma experiences. During the early days of Levi's treatment, both the therapist and the trauma consultant have maintained contact with the residential staff who support him, helping them to establish a "safe space" in his home. They helped Levi learn how to let staff know when he is becoming dysregulated and how to utilize the space, ultimately preventing him from having to resort to aggression. These strategies were very effective, particularly early in treatment when Levi was still having difficulty putting his emotions and pain into words. The therapist further supported the residential staff by helping them understand all the ways that Levi was trying to communicate with them. Later in treatment, the therapist began working with Levi to talk about his future dreams and how he could move toward these goals, while working with

residential staff and Levi to focus on more than just behaviors and consequences – including processing early trauma and understanding how his early experiences have impacted Levi emotionally.

Throughout treatment, the therapist also adjusted the more typical treatment strategies as needed, taking into consideration the following:

- Levi's chronological and developmental age
- Challenges with verbal expression
- Need for extensive repetition before mastery and use of skills
- History of trauma
- Need for concrete strategies and ideas
- Building Levi's tolerance for therapy and "holding" difficult emotions
- His current relationship with his mother and his grandmother

Initially, one of the residential staff attended all of Levi's therapy sessions to help him feel comfortable. Gradually, as Levi and his therapist developed rapport and Levi was feeling safe, the residential staff member was more frequently able to step back and allow the therapist and Levi to meet alone.

A year since initial referral, Levi continues to participate in trauma therapy at Theiss. His incidents of aggression have greatly declined, and he is beginning to move toward increased time in the community with reduced levels of support. Levi's ultimate goal is to transition out of residential placement into his own home with minimal support. As everyone recognizes that success is not a "straight line" process, the therapist and residential staff continue to maintain open communication and adjust treatment strategies as needed and at Levi's own pace, in order

to support his progress. Levi's success has been largely due to the collaborative work between the trauma therapist and the care providers, all becoming much more skilled in applying our knowledge of early trauma to Levi's day-to-day needs.

Trauma-Proficient IDD Services

Professional development opportunities about trauma and the impact of those traumatic experiences on the mental health of children and adolescents are becoming increasingly accessible. Few professionals working with children today would reject the notion that trauma can have a profound impact on development and behavioral health outcomes. However, there is significant variation in how being trauma-informed impacts the day-to-day work of teachers, therapists, caseworkers, etc. It is therefore important to move beyond *trauma-informed* care, to *trauma-proficient* care. This demands a different type of training, one that moves from providing information to caregivers to the *application* of knowledge about trauma to everyday *practice*.

The Theiss Center for Child and Adolescent Trauma not only supports the implementation of evidence-based treatment within UPMC's child and adolescent trauma specialty outpatient clinic, but it also provides a mechanism through which child and adolescent clinicians may become trauma proficient, not just trauma informed. This mission is supported through training UPMC clinicians and graduate students in evidence-based treatments for trauma, as well as by offering professional development opportunities that provide practical, practice-oriented information, and a mechanism through which to assist programs in becoming trauma proficient in the work they do with traumatized children and families.

The Theiss Training Center was established to develop and deliver professional development programs that better equip professionals to provide services to children and adolescents with

trauma histories across the UPMC Western Behavioral Health Network and beyond. The inaugural offering of the Theiss Training Center is a child trauma curriculum that provides a framework for use by clinicians and programs across target populations, clinical specialties, and levels of care. This curriculum begins with foundational general concepts in trauma and child development and moves toward integration into practice, focusing upon training tailored to individual clinic/population needs. Ideally, participants are encouraged to progress in sequence through the components to achieve the best training outcomes. Overall, the curriculum helps participants understand how early traumatic events can impact the emotional and behavioral functioning of children with a variety of clinical presentations and treatment needs. More specifically, the Theiss child trauma curriculum includes the following components.

- **Trauma Foundations**: Understanding how early traumatic experiences impact child and adolescent development, identity, and behavior is critical to providing quality mental health care. A *Child Trauma Lecture* provides foundational concepts related to trauma, including the impact of child trauma on brain development, personality, relationships, and behavior. This didactic focuses on general clinical practice with children, delivers a detailed discussion about the impact of early attachments on mental health, and explores the influence of intergenerational trauma on child and family functioning. This component integrates information from a variety of sources including Infant Mental Health principles, early attachment models, Child Parent Psychotherapy foundational concepts (an evidence-based trauma treatment modality focusing on young children), current research regarding the impact of early trauma experiences on developmental processes, and the training developer's extensive treatment experience.

- **Trauma Demonstration:** Training that provides a seamless transition from theory to practice is vital for clinicians to truly develop the skills to become trauma-proficient in clinical work. After providing the foundational knowledge on trauma and developmental theory, training shifts to *demonstrating* how trauma histories can impact a child's current behavior and how to incorporate these concepts into treatment planning. This component is called the *Child Trauma Laboratory.* Drawing heavily from psychosocial theories of development, the trainer uses fictitious case examples of children with different behavioral health presentations to demonstrate how to move from a conceptual understanding of the developmental impact of trauma to individualized treatment planning and intervention. In addition, this component also includes a review of the impact of secondary traumatic stress on clinician functioning and client outcomes.
- **Trauma Application:** The third component provides more in-depth instruction though the *direct application* of trauma concepts to specific clinics and their populations (*Child Trauma Practice*), including providers who serve children with IDD. This component is typically provided at the training participants' clinic or program and incorporates information from their specific clients. Participants are asked to bring detailed social histories for real clinical cases, excluding any identifiable information. Within the context of psychosocial and attachment theories, the trainer then helps the participant plot the child's early traumatic events on a timeline, analyze the potential impact of these traumatic events, discuss how these trauma experiences are influencing the child's current functioning, and most

importantly, discuss recommendations regarding how all this valuable information can now inform current treatment.

- **Consultation:** To reinforce the development of trauma proficiency in clinical practice, ongoing *consultation* is available for individual clinics to support the incorporation of trauma-focused concepts into treatment. Consultation support can be scheduled regularly, or as needed, depending on clinic preference. It is anticipated that consultation may be more frequent immediately following the *Child Trauma Practice* training and then tapered down over time as the concepts take hold in clinical standards of care. As in Levi's case, the ability of the trauma therapist to collaborate with caregivers, and the ability for caregivers to obtain training and ongoing specific consultation on how to support Levi across environments, allowed for dramatic improvements in behavioral health functioning.

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Biographies

Kimberly Blair, PhD, is a licensed psychologist and an Associate Professor in the University of Pittsburgh Department of Psychiatry. As part of her role with the University of Pittsburgh, in 2005, Dr. Blair was appointed as the Director of the children's early childhood behavioral health programs at the Matilda Theiss Early Childhood Center in Pittsburgh, the cornerstone of early childhood mental health services at UPMC Western Behavioral Health. In 2012, Dr. Blair established what is now the Pittsburgh-based Theiss Center for Child and Adolescent Trauma, part of the National Child Traumatic Stress Network and funded by grants from Substance Abuse and Mental Health Services Administration (SAMHSA). Dr. Blair is currently serving as the program director for the Child & Adolescent Trauma Services Outpatient Clinic. The current NCTSN Complex Child & Adolescent Trauma Project is working to expand trauma treatment access to children ages 2 through 17, as well as provide trauma training and consultation across UPMC Western Behavioral Health programs and beyond.

Teri Pentz, MS, LPC, has over 25 years of experience working with children and their families, both in Early Intervention and in Infant and Early Childhood mental health. She has a master's degree in Counseling Psychology, is a board certified Licensed Professional counselor, and has earned Infant Mental Health endorsement (IMH-E®) through Michigan AIMH and Pennsylvania AIMH at the Clinical Mentor level. She has been a direct service provider, Service Coordinator, and supervisor for Early Intervention and Behavioral Health services within several agencies and counties and has participated in intervention services for children of all ages across her various positions. Currently, Teri works at the Theiss Center for Child and Adolescent Trauma as a supervisor, therapist, and trainer, specializing in Child-Parent Psychotherapy and working with young children who have experienced trauma including issues with attachment, as well as children of adoption.

Alonzo L. Alston, MS, LPC, earned his Master of Science Degree from Slippery Rock University in Community Counseling and acquired his License in Professional Counseling (LPC). For the past three years Alonzo has been employed as an outpatient therapist at Theiss Center for Child and Adolescent Trauma at UPMC. Alonzo has over twenty-five years of experience working with children and adolescent trauma clients in various treatment settings. He began his career completing individual and group therapy services for children and families in residential settings, going on to work with homeless children and families completing mental health assessments, offering treatment linkages, and completing therapeutic services, and then returning to work with adolescents with conduct issues in residential settings before joining the outpatient trauma clinic at UPMC Western Behavioral Health.

Tara Pavlocak, MSW, is a Research Program Administrator with UPMC and is currently responsible for day-to-day management of the Theiss Complex Child and Adolescent Trauma Project. She has a Master of Social Work degree from the University of Pittsburgh with a specialization in Community Organizing/Social Administration and is a Dean's Scholar Award winner. Tara has 20 years of community and non-profit experience with an emphasis on federal/state and foundation grant proposal writing and grant project implementation and management. Tara has had a vital role in the growth and continued funding of the SAMHSA-

funded, NCTSN Category III Theiss Center for Child and Adolescent Trauma since its inception in 2012 and has served as its manager since 2013.

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