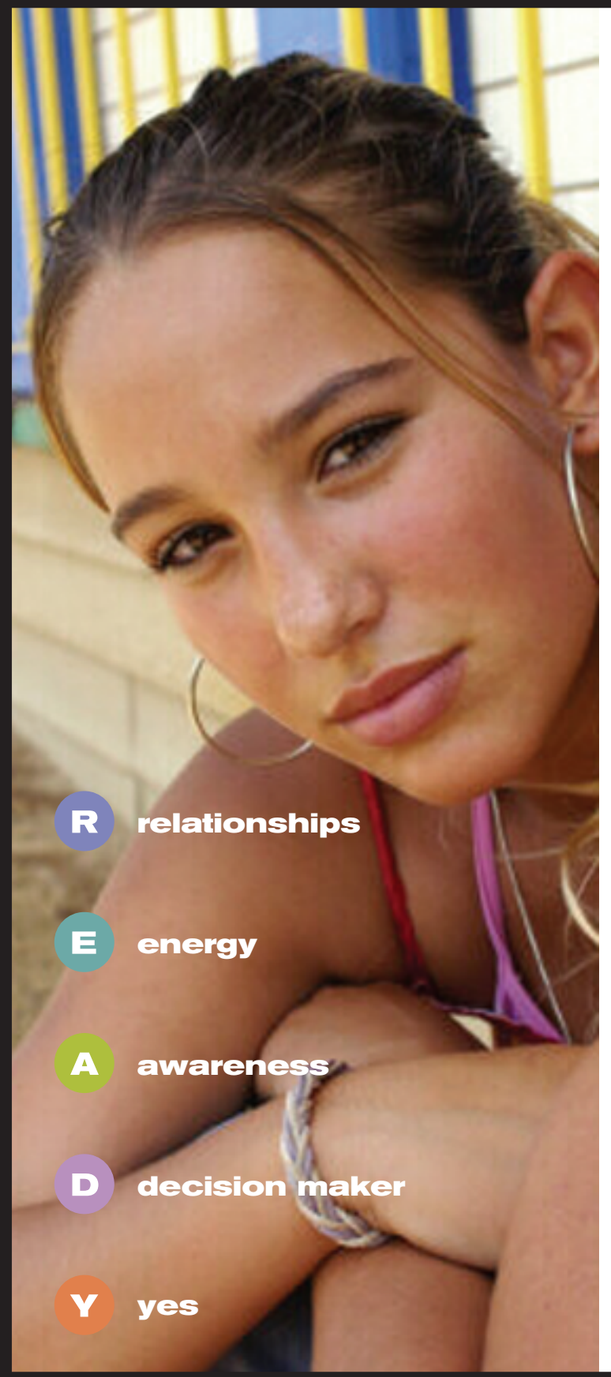


If you would like more information on adolescent parenting issues, please call the Vermont Parents Assistance Line at:

1-800-PARENTS

VERMONT FAMILIES Talk!

Vermont Department of Health
108 Cherry Street
Burlington, VT 05401

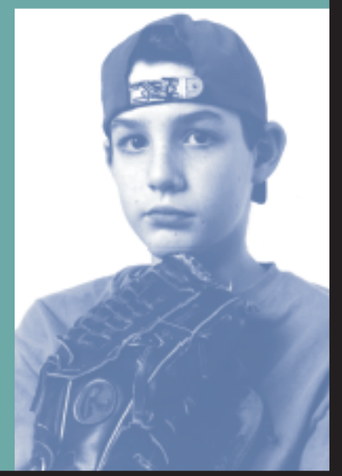
READY

FOR LIFE:

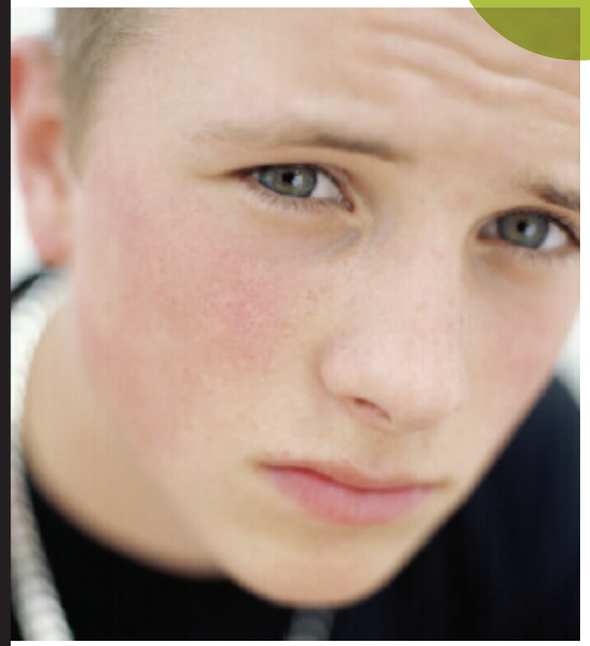
Building Adolescent Strengths

Are you worried about early and risky sexual behavior, drugs, drinking and school failure?

Most parents have instinctively been building their children's strengths since infancy but sometimes the positive messages can become buried in adolescence.



READY



Being the parent of an adolescent is a challenging and rewarding time. You watch your child develop talents and strengths for a successful adult life while at the same time learning to avoid some of the risks of youth.

Always, parents ask, "What can I do to help my child through all the ups and downs of adolescence?" Today's parents worry about drugs, drinking and smoking, early and risky sexual behavior, school failure, and any number of social and relationship problems.

There seems to be a lot of negative news for parents to hear. However there is good news for parents based on our most recent years of research. Researchers have been finding that parents can help prevent problem adolescent behaviors and promote healthy development by helping their teens build on their strengths.

The Vermont Child Health Improvement Program has developed an approach called **READY**, based on that research. The **READY** plan outlines areas of strength that will help adolescents grow successfully through their teen years. It offers parents a way to focus on those areas of strength and help their teens in a positive way.

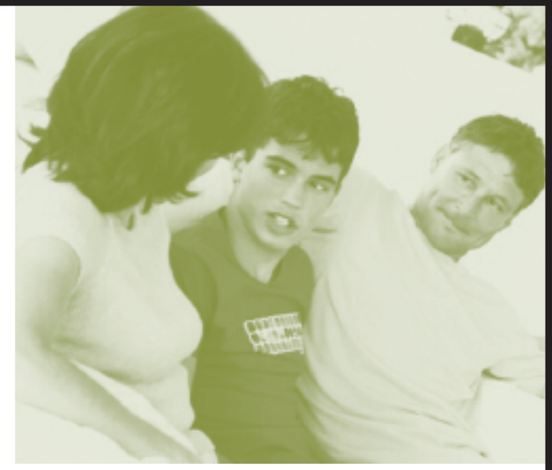
R stands for relationships with friends, other students, coworkers and family. Does your child build strong relationships with the other important people in his or her life? A teenager who feels strong bonds with family members and friends has a major strength. A primary goal of parents is to love and connect with their children. Children are much more likely than parents may think to adopt their parents' values, especially when they feel loved and connected.

E stands for energy. It's the energy to give to the things they enjoy. Many parents of strong, resilient teenagers have spent considerable effort helping their youngsters find activities that they enjoy and that give them a way to happily participate.

A stands for awareness. It's awareness of the world around them, their place in the world and their contribution. A healthy adolescent is growing into that awareness. That awareness is leading to a sense of direction and belonging, of learning how to make his or her own contribution. One way to develop this strength is through volunteer activities. Parents can help their teens learn to be contributors, enjoying a positive relationship with their community.

D stands for decision maker. Adolescents who know how to get things done and can control their behavior will have an important strength in avoiding adolescent risk behaviors. This is a major strength that leads to success in school and in extra-curricular activities. Parents can have an important role in providing opportunities for their youth to become successful decision makers.

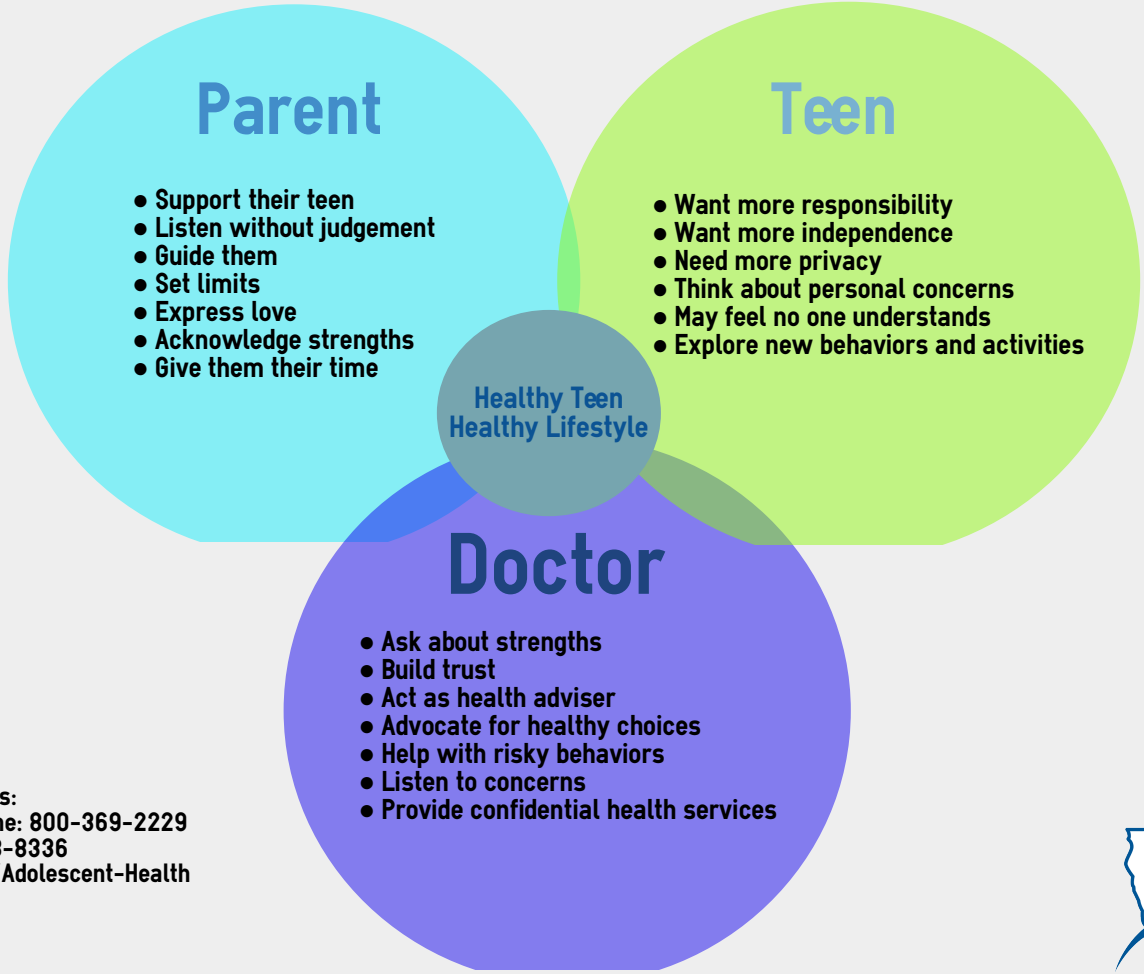
Y stands for "Yes". A strong teenager will say yes to healthy behavior; he or she will eat well, play hard, work hard. Parents can help by modeling that healthy behavior and affirming it when they see it in their own children.



With a renewed effort to approach the challenges of adolescence in a positive, strength-building way, families, pediatricians, teachers, and others working with our youth can give young people the tools they need to be successful.

Understanding the Roles

Teens experience many changes, from physical and emotional changes to social roles and relationship changes. Creating healthy behaviors early on will play an important role into adulthood. Teens need involved parents and doctors. However, they also need privacy.



Additional Resources:
Healthy Families Line: 800-369-2229
TEEN Line: 800-443-8336
www.idph.iow.gov/Adolescent-Health

IDPH
Iowa Department of Public Health

The 5 Basics of Parenting Adolescents

Adapted from "Raising Teens: A Synthesis of Research and a Foundation for Action"

1. LOVE AND CONNECT

Teens need a connection with their parents. Continue to support and accept your teen as she/he gets older and more mature.

Tips for Parents:

- Say good things about your teen when he or she does something well.
- Enjoy the good times you spend with your teen.
- Your teen will challenge your point of view. Discuss your ideas with your teen. It's OK to have a difference in opinion.
- Spend time just listening to what your teen is feeling, thinking, and experiencing.
- Treat each teen as a unique individual.
- Encourage your teen to build his or her interests, strengths, and talents.
- Provide meaningful roles for your teen in the family.
- Spend time together one-on-one and as a family.

Key Message for Parents:
Their world is changing. Make sure your love doesn't.

2. MONITOR AND OBSERVE

Teens need parents to know what is going on in their lives. Be aware of what they are doing in school and after school. Let them know you are aware of their activities. Find out what is going on by talking, not by constantly watching your teen.

Key Message for Parents:
Pay attention to your teen's activities. Your involvement matters.

Tips for Parents:

- Know where your teen is and what he or she is doing. Listen, observe, and talk with other adults who know your teen.
- Keep in touch with the other adults in your teen's life. They will let you know how he or she is doing when you are not there. Ask to know the good and the bad.
- Involve yourself in school events.
- Stay on top of information about your teen's classes, grades, job, and interests.
- Learn and watch for warning signs of physical and mental health problems.
- Ask for advice if you notice any warning signs.
- Be aware of the relationships your teen has in and outside of the home.
- Encourage your teen to challenge him or herself.

3. GUIDE AND LIMIT

Teens need parents to set clear limits. These limits should protect your teen from unsafe situations and give him/her room to grow and mature.

Key Message for Parents:
Remember to be both firm and flexible.

Tips for Parents:

- Keep two kinds of "house rules." The rules around safety cannot be argued. The rules around household tasks and schedules can be discussed.
- Have clear expectations that are high and also reasonable.
- Stand firm on the important issues such as safety and let go of the smaller issues.
- Help teens make better choices by teaching them, rather than punishing them.
- Enforce rules without hurting your teen's body or feelings.
- Give your teen more duties and more choices as they grow into adults.

The 5 Basics of Parenting Adolescents (continued)

MODEL AND CONSULT

Teens need parents to help them make good choices and guide them while they grow into adults. Talk to your teen, support him or her, and teach by example!

Tips for Parents:

- Set a good example by behaving the way you want your teens to behave.
- Share your opinions with your teen.
- Model the kind of relationships that you would like your teen to have.
- Give teens truthful answers when they ask questions. Keep in mind their level of understanding.
- Take pride in your family customs. Share your family's culture and history with your teen.
- Support your teen's positive school and work habits and interests.
- Help teens plan for their future and talk about their options.
- Give teens the chance to solve their own problems and make decisions.

Key Message for Parents:
Be a good example for your teen.

PROVIDE AND ADVOCATE

Teens need parents to give them healthy food, clothing, shelter, and health care. They also need a caring home and loving adults in their lives.

Key Message for Parents:
Trust your teen while guiding her or him to better choices.

Tips for Parents:

- Meet with people in your neighborhood, schools, and local groups.
- Locate the best schools and youth programs for your teen.
- Choose the safest neighborhood you can for your teen.
- Make sure your teen gets yearly health check-ups and the mental health care he or she needs.
- Find people and local groups that will help you be a better parent.

RESOURCES

- **Positive Parenting. KidsHealth for Parents:**
  www.kidshealth.org/parent/positive
  Articles in English and Spanish.
- **Parenting. About Our Kids:**
  www.aboutourkids.org/aboutour/articles_parenting.html
  Articles in English and some in Spanish, Chinese & Korean.

Do you have any comments or questions about this handout? Please contact Adolescent Health Working Group by emailing feedback@ahwg.net or calling (415) 554-8429. Thank you.

[1] Simpson AR. Raising Teens: A Synthesis of Research and a Foundation for Action. Center for Health Communication, Harvard School of Public Health. 2001, http://hrweb.mit.edu/worklife/rpteens.html. Adapted with permission.

PARENT

YOUR TEEN IS CHANGING!

The teen years are a time of growth and change as your teen moves from being a child to an adult.

As your teen changes, your role as a parent changes. You will relate to your 12 year old differently than your 18 year old. It is important to know what to expect, so that you can give your teen more responsibility and the best possible advice.

YOUR TEEN MIGHT:

- Become more independent
- Want more responsibility
- Push boundaries and test limits
- Want their relationship with you to change
- Need more privacy
- Have mood swings
- Think a lot more about their own personal concerns
- Place more importance on friends
- Feel that no one understands them
- Tryout new behaviors and activities – both healthy and risky
- Understand complicated concepts instead of just the here and now

YOUR TEEN STILL NEEDS YOU TO:

- Give them your time
- Give them a sense of connection or belonging
- Support them
- Provide for their basic needs
- Guide them
- Express your love
- Set limits
- Pay attention to their successes and behaviors
- Be involved and aware of what is going on in their lives

REMEMBER:

All of these changes are perfectly normal! Your teen still needs you, but may not always know how to communicate that. You are still the best person to guide your teen, and it is important to keep talking with them.

Talk to your teen's doctor or nurse about these changes and any challenges you may have with your teen.

WEBSITES FOR PARENTS:

RESOURCES

Children Now and Kaiser Family Foundation
http://www.talkingwithkids.org

Advocates for Youth
http://www.advocatesforyouth.org/

SIECUS– Families are Talking
http://www.familiesaretalking.org

California Family Health Council–Talk with Your Kids
http://www.talkwithyourkids.org/

US Department of Health & Human Services– Parents Speak Up
http://www.4parents.gov/

Nickelodeon–Parents Connect
http://www.parentsconnect.com

TALKING TO YOUR TEEN ABOUT TOUGH ISSUES

The natural changes that happen during the teen years can be hard for you and your teen. In many families, there may be disagreements as teens want more privacy and independence. Parents might feel that their teens are moody and disrespectful.

Teens make decisions about things like sex, smoking, alcohol and drugs. As an adult, you continue to make decisions about these things, too. As the parent of a teen, you have the opportunity and responsibility to help them learn how to make healthy decisions. Teens want information and a close relationship with their parents. Even though it can be hard, it is important to talk openly and often with your teen about these issues.

Tips for talking with your teen:

Talk:	Don't be afraid to talk about tough subjects like sex and drugs. Even if your child is only 10 or 11 years old, you can talk about puberty, peer pressure, and staying healthy. This will let your teen know that it is ok to talk with you about these issues.
Listen:	It is important to listen and be open to your teen's opinions. Try not to interrupt while they are telling you their point of view.
Be honest:	Give truthful answers when your teen asks for information. Don't worry if you don't have all the answers.
Share your ideas and opinions:	Teens want to hear about your values and beliefs.
Respect their opinions:	Teens become more mature and independent, and letting them make their own choices is an important part of growing up. Ask them for their ideas and opinions. Make sure to let them know you are always there to help, even if you do not agree with all of their decisions or behaviors.
Stay calm:	Try to stay calm if they come to you with a problem that is upsetting, so they will not be afraid to talk to you.
Keep talking:	Bring up subjects over and over again. Don't be afraid to bring up important topics that you have already talked about. Use movies, TV shows or news stories about teen health as a way to start discussions.

Don't be afraid to ask for help!

P PARENT

HELPING YOUR TEEN TAKE RESPONSIBILITY FOR THEIR HEALTH

Raising teens can be tough. Sometimes they want you around and sometimes they don't. Sometimes they are responsible and sometimes they are not. Teens need involved parents, but they also need some privacy when it comes to their health. With privacy, they can talk openly to their doctor about their concerns. Without privacy they may avoid going for certain services. These may be called "confidential" or "sensitive" services.

For most types of medical care, parents need to give consent and they can get information about their teen's doctor's visits. But under California law teens can get private care without parent consent for some "confidential" or "sensitive" visits, such as those for:

- Birth control
- Pregnancy
- Sexually transmitted diseases (for ages 12 and older)
- Sexual assault services
- Mental health counseling (for ages 12 and older)
- Alcohol and drug counseling (for ages 12 and older)

Don't I have a right to know what medical care my teen is getting?
Why can my teen go to the doctor for these serious issues without me knowing about it?

Every state has laws for children under 18 to get certain kinds of health care without their parents' consent. Fortunately, MOST teens DO talk to their parents, and they want their parents' advice. You play an important role in helping them stay healthy! But even if the relationship between you and your teen is strong, there are some issues that your teen may want to get care for on his or her own. Teens may be embarrassed, ashamed, or scared to talk to parents about some issues. They may not go to the doctor unless they know the information would be kept private.

What will happen if my child is in danger?

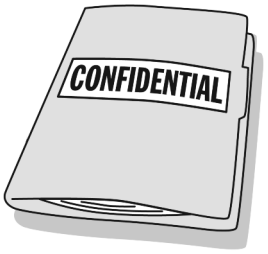
There are some limits to confidentiality. If a doctor or nurse learns that a teen under 18 years is being abused, or is thinking about hurting him/her self or others, the proper authorities must be contacted for help.

Will my teen keep secrets from me since they can get confidential services?

Wanting privacy is a healthy and normal part of growing up. Even though teens are able to get some medical care without parent permission, doctors and nurses encourage them to talk to their parents or another trusted adult.

How can I let my teen know I want to talk to them about these kinds of issues?

As the parent of a teen, part of your job is helping them learn how to make healthy decisions. They are becoming more independent, and making their own choices is an important part of growing up. Make sure you let them know you are always there to help, even if you do not agree with all their decisions. Listen, and when possible, stay calm if they come to you with a problem that is upsetting, so they will continue to talk to you.



KNOW MYSELF, KNOW MY TEEN

Sometimes your opinions can stand in the way of listening to your teen with an open mind. If teens feel judged by their parents or guardians, they are less likely to share information that may be sensitive, embarrassing, or hard to talk about. Ask yourself these questions before you talk about sensitive issues with your teen.

How do I feel?

What is your mood? What are the memories that may shape your opinions? Keep in mind that what you went through as a teen may be different from what your teen is going through now.

What was I doing when I was 16?

Have you thought about what you want to share with your teen? Hold off on sharing sensitive information with your teen until he/she is in the middle teen years.

Are we finding some time together to enjoy each other?

It may be hard to believe, but most teens say they wish they had more time with their parents. Difficult topics may be easier to talk about when you spend enjoyable times together like going for walks, watching movies, doing projects, or sharing meals.

Am I listening to my teen?

Spend as much time listening as you do talking. Avoid making quick judgments. If you do not understand what your teen is trying to say, repeat what they have said back to them.

Do I judge too quickly?

Always ask your teen what she or he is doing rather than thinking the worst. Trust that he or she can make good decisions.

What are my rules about safety?

Tell your teen which rules must be followed for his or her safety. Follow through with consequences if your teen behaves in unsafe ways. Talk about the importance of safety on a regular basis, not only once. Get help immediately if your teen is in an unsafe situation.

Am I willing to get help for any problems I may have?

It is important to be an example for your teen. Seeing family members get help will encourage your teen to get help for his or her own problems.

Adapted with permission from "Are you An Askable Parent?" Advocates for Youth, Washington, DC. www.advocatesforyouth.org

THE 5 BASICS OF HOW TO PARENT TEENS

1. LOVE AND CONNECT

Support and accept your teen as she/he gets older. Their world is changing. Make sure your love doesn't.

Tips for Parents:
- Say good things about your teen when he or she does something well.
- Support your teen's interests, strengths, and talents.
- Spend time one-on-one and as a family.
- Get to know your teen's friends and their parents/caregivers.

2. WATCH AND OBSERVE

Find out what is going on by talking with your teen. Notice your teen's activities.Your interest matters to them.

Tips for Parents:
- Talk with the other adults in your teen's life.
- Be aware of your teen's classes, grades, job, and interests.
- Know where your teen is, what he or she is doing, and who your teen is with.

3. TEACH AND LIMIT

Limits protect your teen from unsafe situations and give him/her room to mature. Be firm, but also be willing to adapt and change your mind.

Tips for parents:
- Help teens make better choices by teaching them instead of punishing them.
- Stand firm on important issues such as safety, and let go of smaller issues.
- Be consistent and follow through with consequences you set up with your teen.
- Be firm about rules without turning to physical punishment.
- Give your teen more responsibility and more freedom to make their own choices as they grow into adults.

4. SHOW AND DISCUSS

Talk to your teen, support him or her, and teach by example!

Tips for Parents:
- Set a good example by behaving the way you want your teen to behave.
- Praise your teen's positive behaviors and habits.
- Give teens the chance to solve their own problems and make their own choices.

5. PROVIDE AND PROMOTE

Teens need parents to give them healthy food, clothing, shelter, and health care.
They also need a caring home and loving adults in their lives.

Tips for Parents:
- Seek out good opportunities and activities for your teen.
- Make sure your teen gets checkups with his/her doctor every year, and any counseling that he or she needs.
- Reach out for support from other parents when you need it!

RESOURCES

Children Now and Kaiser Family Foundation
http://www.talkingwithkids.org

Advocates for Youth
http://www.advocatesforyouth.org/

SIECUS– Families are Talking
http://www.familiesaretalking.org

California Family Health Council–Talk with Your Kids
http://www.talkwithyourkids.org/

US Department of Health & Human Services–Parents Speak Up
http://www.4parents.gov/

Nickelodeon–Parents Connect
http://www.parentsconnect.com

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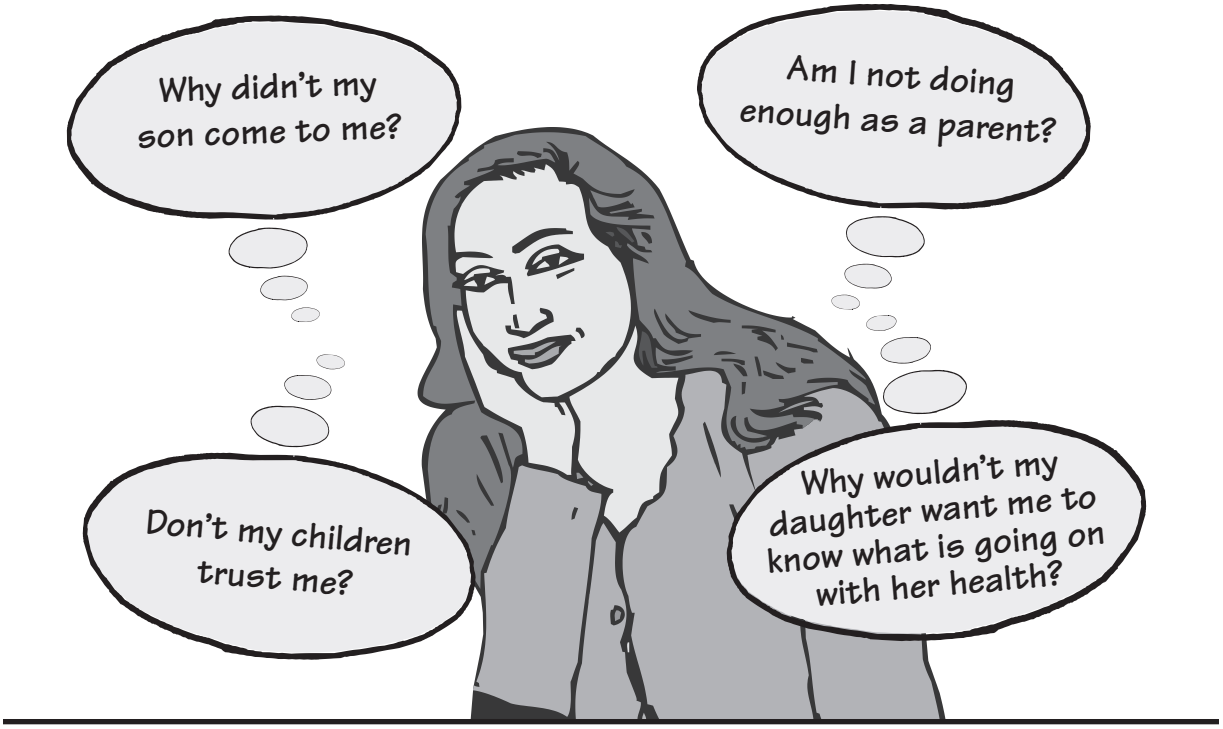
PARENT

MY TEEN IS GOING TO THE DOCTOR AND NOT TELLING ME!



You just found out that your teen is getting medical services without telling you. As a parent you may be worried and upset when this happens. This is normal. But try thinking about it this way – your teen is being responsible for <u>their</u> health. This is something you can be proud of!

Remember:

- Your teen is becoming more independent. As teens get older they try out more adult behaviors, and may want to find help on their own. This is an important part of growing up.
- You are important to your teen and their health! But even when teens and parents have strong relationships, there are some issues that your teen may want to talk to their doctor about on their own.
- It is never too late to talk to your teen about tough subjects. Start by talking about your own values and expectations. It is important that you:
  - ✔ Stay calm
  - ✔ Listen
  - ✔ Respect <u>their</u> ideas
  - ✔ Share your thoughts and opinions
  - ✔ Do not lecture
- Doctors and nurses want to help and support you. Ask them for help if you have concerns or questions about your teen.

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Strength-Based Interviewing

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[c]*Vermont Child Health Improvement Program, University of Vermont College of Medicine, 1 South Prospect Street, Burlington, VT 05401, USA*

Bright Futures,[1] in its 2007 guidelines, called for an assessment of adolescent development and the use of strength-based approaches in the adolescent health supervision visit. The 7 developmental tasks of adolescence noted in the developmental surveillance at each yearly visit include:

- healthy behaviors;
- caring and supportive relationships;
- physical, cognitive, emotional, social, and moral competencies;
- self-confidence, hopefulness, and well-being;
- resiliency, when confronted with life stressors;
- responsible and independent decision-making; and
- positive engagement in the life of the community.[2]

Using strength-based approaches in the clinical setting requires that clinicians have the following skills and knowledge:

- understanding what constitutes strengths;
- knowing how to ask about and elicit strengths by using a framework;
- improving youth confidence by reflecting strengths back to youth and their parents;
- providing guidance about adding strengths in domains where they may be lacking; and
- using shared decision-making strategies when behavior change is needed.

The rationale for using a strength-based approach and building developmental assets has been reviewed by us previously.[3] Risk assessment is still mandatory,

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especially for the health behaviors that contribute the most to adolescent and adult morbidity and mortality. These risk behaviors include inadequate physical activity and nutrition, sexual behavior that may lead to unintended pregnancy or infection, substance use and abuse, and behaviors that contribute to unintentional injuries and violence (ie, homicide/suicide).[4] Much of our literature review focused on finding a lower number of these risky behaviors in youth who had a greater number of developmental assets.[1,5–8]

A list of approaches that the medical home can use to support healthy adolescent development (eg, physical and psychological safety, supportive relationships, and opportunities for skill building) was provided in our previous article (see Table 3 in ref[3]). This list was adopted from a report on community approaches prepared by Eccles for the National Research Council and Institute of Medicine Committee on Community- Level Programs.[9]

The advocacy for strength-based approaches in the medical home is supported by the field of positive psychology, which builds on Bandura's social cognitive theory.[10] Both emphasize self-efficacy. A list of strengths that enable human thriving[11] can also inform this work. In addition to facilitation of self-management and behavior change, strength-based approaches can also result in more positive engagement with youth and their parents.

The work described here, which has been developed over the past 8 years, was inspired by the work of Brendtro, Van Bockem, and Brokenleg,[12] Benson,[13] and Pittman et al[14] and initiatives of the Vermont Agency of Human Services and Vermont Regional Partnerships, which have focused on community and school-level interventions.

To participate in this strength-based model, health care practitioners needed clinically workable models for integrating these services into their busy practices. Design of the practice-level implementation involved input from adolescents, parents, and professionals from schools, community groups, and youth-serving agencies as well as health care and mental health professionals. Actual implementation relied on the expertise and suggestions of Vermont pediatricians, family physicians, nurse practitioners, physician assistants and nurses, in the settings of practices, clinics, and school-based health centers.

The Search Institute work identifies 40 assets arranged in the following categories: support, empowerment, boundaries and expectations, constructive use of time, commitment to learning, positive values, social competencies, and positive identity.[5] Pittman has focused on 5 C's (competence, connection, contribution, character, and confidence)[14]; Brendtro et al, in the Circle of Courage, identified the importance of generosity, independence, mastery, and belonging.[12] Our practices were given an opportunity to choose 1 of these frameworks, and almost all chose the Circle of Courage model. Many practices have implemented

strength-based approaches and have allowed chart audits to measure their use as part of a quality improvement effort.[15] Many health care professionals, parents, and advocates in various settings outside Vermont have participated in workshops on strength-based approaches and have shared their ideas and experiences.

Several other pediatricians have devoted significant effort to similar issues, and their contributions have provided additional examples and tools for the incorporation of strengths into preventive services. Ginsberg has recommended the use of the SSHADESS (strengths, school, home, activities, drugs, emotions/depression, sexuality, safety) interview format[16] and the 7 C's, adding coping and control to Pittman's 5 C's.[17] Sege served as the project director and co-editor with Spivak, Flanigan, and Licenziato for the American Academy of Pediatrics *Connected Kids: Safe, Strong, Secure Clinical Guide* (2007).[18] *Connected Kids*, which includes parent handouts and a practitioner guide, outlines a strength-based approach to violence prevention.

IDENTIFYING STRENGTHS: A PRACTICAL APPROACH

Most pediatricians are already asking a lot of questions about strengths, although not necessarily in a systematic way. We commonly ask questions related to mastery and belonging, but adolescents need to develop all the strengths to be successful adults. Incorporating strengths in your adolescent interviews is not an "add-on" to the clinical visit but, rather, a rethinking of the way you work with adolescents, a way to efficiently reorganize and prioritize the content of anticipatory guidance.[19] The goals of a strength-based approach are to raise adolescents' awareness of their developing strengths and to motivate them to take responsibility for the role they can play in their own health and well-being. Discussing strengths orients youth toward actively seeking out and acquiring the personal, environmental, and social assets that are the "building blocks" of future success.

If you are already using a HEADSSS (home, education, activities, drugs, sexual activity/sexual identity, suicide/depression, and safety) type of interview strategy,[20] you would just need to add a few more questions (Table 1). Ginsburg has suggested using the SSHADESS format[16] as a way to remember to ask about strengths. He comments that "we risk losing the opportunity to inspire (adolescents) when they quietly become defensive and close themselves off."[16] Respectful, reflective listening, rather than teaching or preaching, allows adolescents to reveal their strengths.

If you choose to use the Brendtro et al Circle of Courage as your framework, you will be asking about strengths in 4 essential areas (Table 2). You would not use all the questions, and you would probably want to ask slightly different questions on the basis of the age of the adolescent and what you already know about his or her strengths and challenges.

Table 1
Using HEEADSSS with a strength-based approach

HEEADSSS Risk Areas	Questions to Help Identify Strengths	Example Responses Indicating the Presence of Strengths	Strengths
Home	Who lives at home with you?	Close family relationships (as opposed to living alone)	Belonging
	What responsibilities do you have at home?	Care-taking responsibilities	Generosity
Education/employment	What's going well at school?	Working with a tutor	Independence
	Are you working?	Working for college money	Mastery
Eating	How do you stay healthy?	Choosing healthy foods	Independence
	What do you think about your diet?	Making healthy meals	Mastery
Peer-related activities	What do you do for fun?	Volunteer/civic activities	Generosity
	Do you have friends you socialize with?	Hanging out with friends	Belonging
Drugs	Do you have friends who use drugs? Do you?	Pledge to abstain	Independence
		Friendships with people who do not use drugs	Belonging
Sexuality	Have you ever had sex?	Consistently responsible behavior	Independence
	Has anyone ever made you do something you didn't want to?	Supportive or understanding relationships	Mastery; belonging
Suicide/depression	What do you do when you feel sad?	Access to a confidant	Belonging
	Do you have someone you talk to about your problems?	Successful coping skills	Mastery; independence
Safety from injury and violence	Do you wear a seatbelt? Do you wear a helmet when riding bikes?	Seatbelt and helmet use	Independence
	Do you feel safe at home?	Feelings of safety or security at home and school	Belonging

Adapted from Goldenring JM, Rosen DS. Getting into adolescents heads: an essential update. *Contemporary Pediatrics*. 2007. Reprinted with permission from Duncan PM, Garcia AC, Frankowski BL, et al. Inspiring healthy adolescent choices: a rationale for and guide to strength promotion in primary care. *J Adolesc Health*. 2007;41(6):531

Some may want to use a different framework with older adolescents. The "READY for Life" framework[21] can work well with older adolescents:

Am I READY for life as an adult[21]?

- Relationships with friends, other students, co-workers, and family

Table 2
Identifying Strengths

Belonging (connection)	How do you get along with the different people in your household?
	What do you like to do together as a family? Do you eat meals together?
	Do you feel you have at least 1 friend or a group of friends with whom you are comfortable?
	What do you and your friends like to do together after school? On weekends?
	How do you feel you "fit in" at school? In your neighborhood?
	Do you feel like you matter in your community?
	Do you have at least 1 adult in your life who cares about you and to whom you can go if you need help?
	When you're stressed out, who do you go to?
Mastery (competence)	What do you do to stay healthy?
	What are you good at?
	How are you doing in school?
	What do you like to do after school with your free time?
	Do you feel you are particularly good at doing a certain thing like math, soccer, theater, cooking, hunting, or anything else?
	What are your responsibilities at home? At school?
Independence (confidence)	Do you feel that you have been allowed to become more independent or make more of your own decisions as you have become older?
	Do you feel you have a say in family rules and decisions?
	Are you able to take responsibility for your actions even when things don't work out perfectly or as you planned?
	Have you figured out a way to control your actions when you're angry or upset?
	Everyone has stress in their lives. Have you figured out how to handle stress?
	How confident are you that you can make a needed change in your life?
Generosity (contribution, character)	What makes your parents proud of you?
	What do your friends like about you the most?
	What do you like about yourself?
	What do you do to help others (at home, or by working with a group at school, church, or community)?
	What do you do to show your parents or siblings that you care about them?
	How do you support your friends when they are trying to do the right thing, like quitting smoking or avoiding alcohol and other substances?

- Energy to give to the things you enjoy
- Awareness of the world around you, your place in the world, and your contribution
- Decision-maker (you know how to get things done and control your behavior)
- Yes—you should say yes to healthy behavior: eat well, play hard, work hard

This can be used to help adolescents take stock of what strengths they already have, on what strengths they need to work, and how they can use strengths to

make needed changes. The READY brochure, written for the parents of adolescents, outlines these concepts further.[21]

TEACHING STRENGTHS TO PARENTS

Pediatricians may find it helpful to explain strengths to parents of adolescents. Just as we use anticipatory guidance in early childhood to help parents watch for expected milestones, the strengths are expected and necessary milestones for adolescents. Parents can play a needed role in encouraging strengths in areas that are lagging. In addition, pediatricians should be committed to recognizing and reinforcing parents' strengths by using a similar framework. Pointing out a parent's strengths can be particularly helpful when he or she is going through a difficult time with an adolescent son or daughter.

Parents are often worried about the risks of adolescence and are sometimes so put off by their own child's behavior that they tend to worry about and focus on the negative aspects of adolescence rather than seeing it as a growth experience for them and their child. Adolescence takes many parents by surprise. By teaching them to "watch out" not only for risky behavior, we can help them see their own child's strengths and help them figure out ways to build strengths that may need boosting. All parents want their children to experience joy, success, love, and hope, and adolescents need to develop all the strengths to end up as happy, productive adults.

strengths = assets = protective factors = developmental milestones for adolescents

Using the Circle of Courage framework is 1 way to explain the strength-based approach to parents.

Mastery

"What am I good at?" Parents need to help their adolescent figure this out, especially if he or she is not a great student. Encourage your adolescent to try sports, clubs, a musical instrument, etc. Make him or her an expert on something in the family (research driving directions on-line before a family trip). Model problem-solving behaviors when something does not go well. Help the adolescent to be persistent when he or she does not succeed at something the first time around (or second). Make him or her feel competent in more than 1 area.

Belonging

"Who do I fit in with? Who do I feel connected to?" Parents are often disappointed as friends become more important, but peer relations are vital to adolescents. Keeping your adolescent attached to your family as he or she develops friendly and romantic relationships is tricky. Get to know your adolescent's

friends and make your home a welcome place for them. Encourage appropriate relationships with other adults you trust. Be sure your child knows to whom he or she can go if there is a problem that he or she does not feel can be shared with you (his or her doctor could be one of these people). Help your adolescent figure out how he or she "fits in" with your extended family ("Your little cousins sure look up to you and love to play soccer with you!"), your neighbors ("If I wasn't home and you had a problem, you could get help from Mrs X or Y." "Let's help Mr Z shovel his driveway/mow his lawn."), his or her school ("Who are the teachers/students you get along with the best?"), and his or her community (attend neighborhood events together, or encourage your adolescent to go with his or her friends), including faith-based organizations.

Independence

This is scary for parents of early adolescents, but we all want our children to grow up and be able to function independently (yet remain attached). For many adolescents, this means starting to make healthy independent decisions for themselves, especially decisions to avoid unhealthy risks. Guide your adolescent in healthy decision-making; let him or her work out the solution to a problem and then run it by you for final approval. Independence also means being responsible; as time goes by, this should happen more and more with less and less reminding from you. Some adolescents have a harder time gaining independent control of their behavior and showing self-discipline. Point out to your adolescent that every time he or she makes a healthy decision and controls his or her behavior without reminders from you, he or she is exercising independence. Encourage confidence in your adolescent by putting your trust in him or her when you assign a task to do. Good teachers will try to do the same thing. Let your adolescent take a leadership role in something he or she is good at.

Generosity

This can be the most difficult strength for some adolescents to develop, because most of them go through a stage when they are naturally self-centered as they try to figure out who they are. Point out and name qualities such as caring, sharing, loyalty, and empathy when you see your adolescent displaying them with his or her friends. Encourage the adolescent to practice these qualities when it is more difficult (eg, with a younger brother or an unpopular classmate). The broadest definition of this strength is the sense of giving back to one's community. This can start with parents involving adolescents in volunteering in their neighborhood, school, or faith-based community. Many older adolescents who have not developed this strength feel like they do not "matter" in their family, school, or community. The ability to feel like what you do matters—that the world (or at least your family, school, or community) is a little better because you are there—is very empowering, gives adolescents confidence and hope, and keeps them engaged.

Armed with these strengths, adolescents can be encouraged to take "healthy" risks. As youth advocate Matt Morton has noted, "If you don't give us healthy risks to take, we'll take unhealthy ones."[22] Remember, it is the taking of risks and failing, then having the strength, confidence, and hope to try again, that helps adolescents become resilient adults.

GOING TO THE NEXT LEVEL: USING STRENGTHS

After eliciting strengths in an adolescent, there are several things a clinician can do with the information. First, you can identify or reflect back the adolescent's strengths as a teaching tool about strengths and youth development (much as we encourage parents to identify or put into words a younger child's emotions). Many talented youth do not recognize their own strengths until they are pointed out to them. Second, you can make suggestions to boost strength areas that may be lacking or deficient, because adolescents need strengths in all areas to become healthy, happy, productive adults. Third, you can use strengths as an engagement strategy to lead into a discussion about a needed behavior change. Fourth, you can bring strengths into a structured discussion about behavior change, such as shared decision-making or motivational interviewing.[23]

Some examples of using the Circle of Courage as a teaching tool for adolescents are as follows:

- For a younger adolescent: "Some kids struggle in middle school or high school and get involved in unhealthy, risky behaviors. Others have an easier time becoming a healthy adult. Young people who develop strengths in these 4 areas seem to be 'protected' from a lot of these risks. I can't help but notice that you have developed strengths in these areas [point out strengths that you have elicited]. Are there any areas you think you could work on getting better at?"
- For an adolescent with special health needs (eg, spina bifida): "Have you heard of the Circle of Courage? It represents strengths I look for in adolescents that can help them mature into healthy adults. I can't help but notice how many strengths you have developed over the past 2 years. You struggled, especially with friendships and independence in middle school, but you're doing well in those areas now. And you've really developed your talent for art, and you are thinking of becoming an art teacher. Generosity, making a contribution in your community, is also important. Have you ever done any volunteer work? Would you consider working with children at the homeless shelter? They have program called 'Art From the Heart,' and I think the kids would really enjoy working with you."

Sometimes we notice that a particular strength is lacking in some adolescents. See Table 3 for some examples of how you and parents can boost needed strengths.

Table 3
Promoting strengths that are lacking

Generosity	
	Ask "What are you doing to help out at home?" "How can you contribute to your community?" Suggest a volunteering commitment that takes advantage of something the youth is good at or interested in. Parents can help steer towards a volunteer experience.
Independence	
	Ask "How do you make a decision about something important?" "How do you control your feelings when you are angry?" Suggest writing down pros and cons the next time they are struggling with a decision, or point out ways to alleviate stress with deep breathing, etc. Parents can help by discussing how they make decisions (about saving money for a needed item, for whom to vote in an election).
Mastery	
	Ask "What are you getting good at?" "What are you interested in outside of school?" Suggest joining a club or sport. Parents can help by providing transportation to or from after-school or weekend meetings or events.
Belonging	
	Ask "Who do you go to for help?" "Who are the adults you trust?" Suggest getting involved in a mentoring program. Parents can help by pointing out relatives or neighbors who can be trusted to go to for help and advice.

What if your patient has a particular problem or challenge? Here are some examples:

- Obesity (strengthen mastery): "Become an expert and take control of your exercise and eating."
- Attention-deficit/hyperactivity disorder (strengthen independence): "You and I have discussed how your attention problems have a biological basis, but you can learn to develop inner control and self-discipline. Learn a way to stop and think before you make an impulsive decision, and practice this skill. The goal is not to get off all your meds, but your appropriate decision-making will make you more independent and get your parents and teachers off your back!"
- Special health needs (developmentally delayed) (strengthen belonging): "Who are your friends, and what do you like to do with them? How are you a good friend? Who are the adults you can go to if you have a problem?"
- "Smart but selfish" (strengthen generosity): "Be aware of the world around you, and see how you can contribute to it. Think about how you could volunteer in the community; maybe you can help set up a Web site for the local teen center. Think about ways you can help out at home or in your extended family."

MAKING STRENGTHS WORK IN DIFFICULT SITUATIONS

Adolescents in difficult situations (eg, those living in foster care or who have dropped out of high school) often have trouble seeing their own strengths and can benefit greatly from having their strengths pointed out to them. For adolescents

who have many challenges, you can use strengths as an "engagement strategy" to enhance communication, help establish trust, promote self-efficacy, and increase patient satisfaction.[16] You can use strengths to work on a needed behavior change by using an established model.

There are several models, from relatively straightforward (the "helping skill"[23]) to more complex (motivational interviewing[24]), that pediatricians can use with adolescents. The "helping skill" involves the following steps: identify the issue; explore the options; consider the consequences; make a plan; and follow-up. Motivational interviewing is a structured set of interviewing skills that help patients move along the stages of change from precontemplation to contemplation, to preparation, and to action. Strategies for motivational interviewing involve expressing empathy, developing discrepancy, avoiding argumentation, rolling with resistance, and supporting self-efficacy. Using strengths can enhance these techniques. The following cases provide a few examples.

Case 1

Tiffaney is a 16-year-old girl who is living in her fifth foster home and fourth school district and comes in for a health supervision visit. She has been in her current foster home for ~9 months and is able to keep the rules pretty well. She has her own room and feels safe. She does some chores but mostly is out of the house. She eats breakfast with both foster parents most mornings. She is a vegetarian and walks 2 or 3 miles per day "getting around" because none of her friends have a car.

She attends public school, is in the 10th grade, and is passing all her courses except one with mostly Cs and Ds. She is failing algebra at the moment, but she loves her art class and gets along well with her teacher. She thinks she may be able to graduate on time in 2 years if she really tries, but it is "a little iffy." She is not sure what she wants to do after high school, but she would like to figure out a way to help kids who are like her.

She had a social worker in a different county whom she still calls and sees occasionally. She feels that this woman helped her a lot with encouragement and choices. She is not currently smoking or drinking, although she has in the past. She now hangs out with a "straight-edge" crowd that does not do drugs of any kind. She is artistic and can draw well. She is interested in body art and has 2 piercings. She keeps a journal and feels that she can express her emotions and thoughts pretty well.

She has had a boyfriend for 6 months, and she spends much of her time with him at his friend's apartment. He works and plays music and enjoys spending time with her and their friends. He tries to support her in her decision to finish high school, although he did not. She has been sexually active with him (her third sexual partner in her life) for 5 months. They use a condom "sometimes," but he

does not really like them. When she is in a car she wears her seatbelt. She describes her mood now as happy and positive. Although she has felt very depressed in the past, she never considered hurting herself.

Her examination is normal. She is in the 50th percentile for height and the 30th percentile for weight; her BMI is in the 25th to 50th percentile.

Tiffaney's risk is unprotected sexual intercourse. Her strengths are:

- generosity (wants to help other kids in foster care);
- independence (expresses herself well, gets around town, makes healthy decisions about substance use, manages her health care);
- mastery (keeping on track at school, art, "survival skills"); and
- belonging (foster parents, art teacher, former social worker, friends, boyfriend).

Use the helping skill:

- Identify the issue: "I just met you and I can't help but notice how many strengths you have . . .. But, I am concerned that you are having sex without using a condom. Can we talk about that?"
- Explore the options with Tiffaney: "What could you do? What else could you do?"
- Consider the consequences of each option that Tiffaney comes up with: "What could happen if you did that? How would that work with your life now?"
- Make a Plan: "It sounds like you are thinking about hormonal birth control, probably the patch. Can I give you a prescription for that today, along with some condoms?" (Tiffaney indicates that she would like to talk it over with her boyfriend first.)
- Follow-up: "That's great! Why don't you make an appointment to come in next Tuesday with your boyfriend and we can talk about it together. Because your pregnancy test today is negative, do you think you two could abstain from sexual intercourse until then?"

Case 2

Carlos, a 17-year-old boy, comes in for a physical for his job.

He lives with his dad, who has a history of involvement with the law for driving while intoxicated. His dad used to hit him but does not really bother with him too much now. He loves his mom, but he thinks that she should take more responsibility for his 3 younger brothers.

He dropped out of school this year in his junior year. He was never good in school, but he did well in weightlifting, and he felt that the coach gave him

encouragement. Because his dad does not give him any financial support beyond a place to live, he decided to drop out of school and work. He thinks he will get a GED (general equivalency diploma) someday, but not right now. He works at a gas station 30 hours/week. Because he likes to talk about car engines, and he likes the money, he is pretty reliable at work. His boss thinks that he is basically a good kid and thinks of him as an apprentice. He is pretty good with his hands and works on 4-wheelers. His dad has one that he rides a lot.

His friends think he is reliable. They like having him around, and they describe him as funny. He always spends 1 evening and 1 weekend afternoon with his brothers, because he wants his brothers to have a guy to look up to because he never did. He is teaching them to shoot hoops and lift weights. He goes to church with them some Sundays.

He eats a lot of "fast food" for breakfast and lunch but often has dinner at his boss' house. He binges on the weekend but usually does not drink more than 1 beer per day after work. He has been in trouble with the law for possession of malt beverage and was picked up for "doing doughnuts" with his car in the school parking lot. He does not use any other substances.

He is sexually active once a month with different partners, and he always uses a condom. He is not depressed or suicidal. He is basically content and deals with what his life has to offer. He wears a helmet whenever he rides his 4-wheeler.

He is proud to be self-reliant. He knows a few things in depth (engines, nature [hunting, fishing]) and almost nothing about many life skills (bank accounts, college applications). He says he would never expect help from outsiders or an "agency."

Carlos' risks are alcohol use and sexual activity with multiple partners. For the alcohol use, use the CRAFFT screening tool[25] with him:

- Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
- Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?
- Do you ever use alcohol/drugs while you are by yourself, alone?
- Do you ever forget things you did while using alcohol or drugs?
- Do your family or friends ever tell you that you should cut down on your drinking or drug use?
- Have you ever gotten into trouble while you were using alcohol or drugs?

Carlos has 2 positive responses on the screen (he has driven while using and has gotten in trouble).

Carlos' strengths are:

- generosity (really cares about his younger brothers);
- independence (has a job, earns his own money, makes some healthy decisions);
- mastery (has a job he is getting good at [but did not finish high school], likes outdoor sports [hunting, fishing] and weight lifting); and
- belonging (family [brothers], friends, boss, church).

Try motivational interviewing:

- "Carlos, I haven't seen you in a couple of years, and I'm impressed with your maturity and sense of independence, and there are so many things you are getting good at. Sounds like your job is going well, although it would be great for you to get your GED sometime soon. Your younger brothers really look up to you, and you are very generous with your time that you spend with them. However, I'm really concerned about how your drinking could affect your health and your plans for the future. Could we talk about that some more?" (Carlos might indicate that, sure, he can talk about it, but he does not see any problem with his drinking, because he is not an alcoholic like his dad. He only got in trouble once, and he will not let that happen again. He is in the precontemplative stage.)
- Develop discrepancy: "Carlos, what do you like about your drinking? What else?" Keep asking until there are no more "good things." (Carlos may indicate that he likes how it makes him feel relaxed, he feels more like a part of the gang at work, he feels his sense of humor is better when he's had a few beers, etc.) "Carlos, what are the 'not-so-good' things about your drinking? What else?" (Keep asking until there are no more not-so-good things. Carlos may indicate that he does not like the way he feels the next morning after he has been drinking, he hates the way his dad tells him he is 'just like him' when he drinks, he disappointed his boss by not showing up for work a couple of times when he felt too 'hung over,' he was really ashamed that his mother and little brothers found out when he got in trouble with the police.)
- "So, it sounds like you enjoy drinking, but it may be starting to interfere with some things that are really important to you, like your job and your relationship with your brothers. What do you make of that?" (Carlos may indicate that he never really thought about it that way.)
- "Would you be willing to start cutting down on your drinking? When would be the easiest time of the week to not use? Could I meet with you next week during your lunch break at work to see how it went?"
- "You have many strengths in your life now, especially your generosity and your sense of independence. I know you can use that independence to help you make the healthiest decision for yourself right now."

Case 3

Rochelle, who is 12½ years old, comes in with her mother for her checkup.

She continues to live at home with both parents and her younger brother. Rochelle gets along "fine" with everyone in the house, although her mother comments that they "clash" over things more than they have in the past. When asked what they disagree on, Rochelle shrugs, and her mother expresses concern about Rochelle's weight. She does mention that Rochelle continues to get along with her younger brother, aged 10, and has a lot of patience with him and helps him with his math homework.

Rochelle just started the 6th grade 2 months ago; this is her first year in middle school. She expresses disappointment that most of her friends from last year are not in her classes, and she occasionally eats lunch by herself. She continues to do well in her classes and got all A's in her first-quarter report card. She did not join the soccer team this year, because she wanted to focus on her schoolwork. In addition, her mother had been finding it difficult to drive Rochelle to practice with her new job. Rochelle now has to baby-sit her brother after school. She does not mind, because they watch television together. Her father has a demanding job in sales that requires him to work 10-hour days and travel a lot, but the family manages to eat dinner together 4 nights per week.

Her diet is "okay," with fruits and vegetables, 2% milk, lots of cheese, and mostly chicken and fish. She usually buys soda at school; there is a new vending machine in the cafeteria. She admits to snacking a lot after school with her brother. She denies the use of tobacco, alcohol, marijuana, and other drugs. Her parents do not smoke, and neither do her friends. She is not interested in any "romantic relationships" at this time, although she does have some friends who are boys, mostly ones with whom she played soccer last year. She has never had sex. She always wears a seatbelt in the car and a helmet on her bike. She used to ride her bike more often but now stays home after school.

Rochelle says that things are "fine," but she is disappointed that school is not as fun as it was in the 5th grade. Her mom has been "getting on her" about her weight, but she thinks it is not her fault, because both her parents are overweight. She says she feels "kind of down" a lot of days but not really bad, and she would never consider harming herself.

On physical examination, Rochelle has sexual maturation ratings (SMRs) of 4 (breasts) and 4 (pubic hair). She is 61 in tall (75th percentile) and 135 lb (95th percentile); her BMI is 25.5 (just below the 95th percentile). The rest of examination is unremarkable. She started her period ~6 months ago and has had it ~3 times; she has had no problems with heavy bleeding or cramps.

Rochelle's risks are:

- poor nutrition (more snacking, soda at school);
- inadequate physical activity (not playing soccer this year, more television time); and
- sadness or depressed mood (misses friends from soccer, school not as fun).

Her strengths are:

- generosity (takes care of her brother after school, helps him with his homework);
- independence (knows how to keep herself and brother safe when parents are not home);
- mastery (good at school, all A's); and
- belonging (family, but not as much with friends now).

Use a written change plan[26]:

- "Rochelle, you are showing a lot of strengths in your life now. You've successfully transitioned to middle school and are keeping up your excellent grades. You are demonstrating independence and maturity by watching your brother after school, and you are very generous to be spending the time helping him with his homework. But, it seems that you are not as active and not eating as well as you were last year, and you seem not as happy with things. Can we talk about that today?" (Rochelle indicates that she really wanted to talk about her weight, because she does not like the way she is looking these days. She wants some help deciding what to do.)
- "Rochelle, on a scale of 1 to 10, with 1 being not ready and 10 being very ready, how ready are you to start making a change?" (Rochelle says 10!)
- "Some people find it helpful to write down their ideas about change. Would you like to fill out this change plan with me today while you are here?"

Fill out the change plan together (see Fig 1), and give her a copy to take home.

TOOLS

If you are just getting started with strengths, pick a framework or model that works well for you (Circle of Courage, 5 C's, READY, etc). Think about what questions you want to ask to identify strengths in each major developmental area. The following are some ideas that have helped other clinicians incorporate strengths in their practice:

- Consider a previsit questionnaire that asks about risks and strengths. Although most practitioners cannot extend the time they spend with patients, the use of tools can help optimize this precious time we do have

How important is it to make a change? **How ready am I to make a change now?**	
__1__2__3__4__5__6__7__8__9__10	
Nutrition	**Physical Activity**
Change:	Change:
How will I make this happen?	How will I make this happen?
Who or what can help me? My strengths: My family's strengths:	Who or what can help me? My strengths: My family's strengths:
What can get in the way?	What can get in the way?
How confident am I that I can make this change? __1__2__3__4__5__6__7__8__9__10	

Return visit: _____

Patient Signature Parent Signature_____Clinician Signature

Fig 1. Fit & healthy change plan. Data source: http://healthvermont.gov/family/fit/documents/Promoting-Healthier-Weight_pediatric_toolkit.pdf.

face-to-face with youth and parents. Instead of asking questions about strengths, this information can be collected by questionnaire, on paper or electronically on a computer or handheld device. Olsen et al[27] have piloted the use of a personal digital assistant (PDA) with an expanded GAPS (Guidelines for Adolescent Preventive Services) questionnaire for use by teenagers in the waiting room. The questionnaire does not substitute for the conversation to elicit strengths, but it gets the youth (and parents if they are going to be involved) thinking in this direction. You can use ones that have been developed or construct your own with your

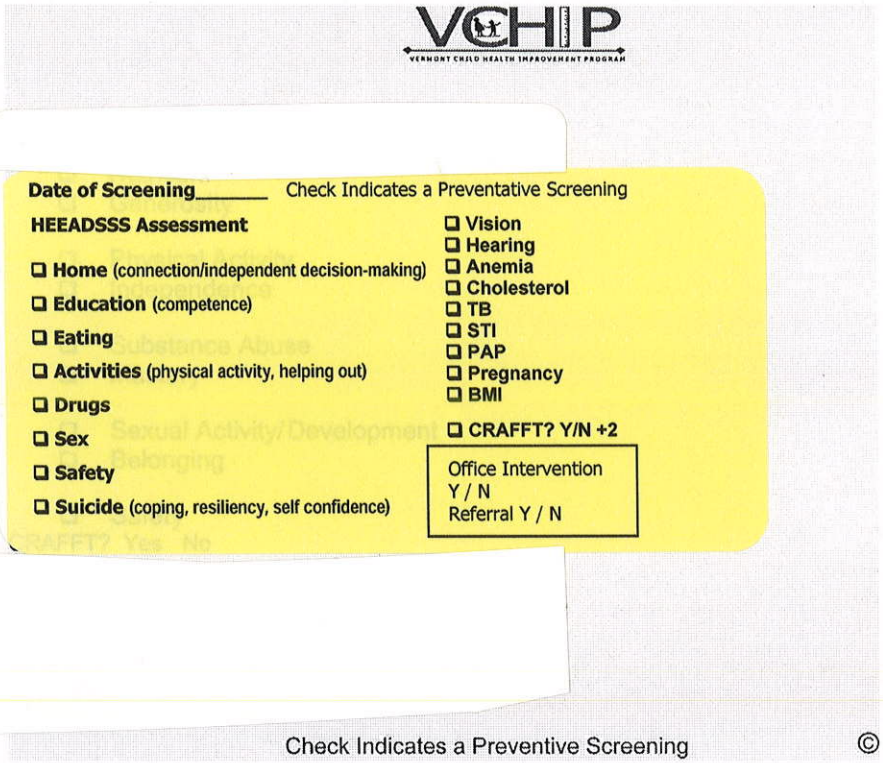

Fig 2. Vermont Child Health Improvement Program (VCHIP) reminder sticker. The sticker is attached to patient charts to remind primary care practitioners to track a set of 6 risk behaviors and 4 wellness-promoting assets during patient screening visits.

favorite questions to elicit strengths. You could also choose questions suggested in Table 2. Consider asking different questions for different age groups. Consider asking parents to describe their adolescent's strengths.

- Use prompts: If you have paper records, you can add a sticker on your encounter form that cues you to ask questions about risks and strengths. The example in Fig 2 was developed by the Vermont Child Health Improvement Program and encourages practitioners to try new interviewing skills before they make changes to their encounter forms.
- You can use a Circle of Courage poster in your examination rooms as your prompt,[28] or the 5 C's or READY brochure. If you are not facile with motivational interviewing, consider using a worksheet such as SMART (Specific, Measurable, Achieveable, Realistic, Time-framed)[29] or a Fit & Healthy change plan worksheet.[26]
- Have educational materials or resources available for parents and/or patients. Some examples could include the READY pamphlet,[21] Gins-

berg's book,[17] *Connected Kids* brochures,[18] parent books, and handouts from the Search Institute.[13]

CONCLUSIONS

In our experience, the implementation of strength-based approaches in the medical home setting requires only a modest restructuring of the visit. A conscious focus on protective factors and strengths does not take the place of the essential risks assessment but, rather, reinforces the commitment of our practitioners and their staff to wellness and health promotion in addition to disease prevention.

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Adolescent Health Update

A Clinical Guide for Pediatricians

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Engaging Adolescents and Building on Their Strengths

by Kenneth R. Ginsburg, MD, MS Ed, FAAP

Adolescent health is tightly linked to behavior. Health professionals are often the only adults a young person sees repeatedly and confidentially throughout adolescence, which positions us to influence adolescent behavior. Our ability to engage adolescents in a health-promoting process is tied to whether we have formed an effective relationship. This means that we must avoid the pitfalls that jeopardize teens' trust, such as lecturing without regard to their readiness to hear the message or failing to consider the context of their lives or the underlying meaning of their behavior. The best of our intentions can backfire when we inadvertently reinforce adolescents' sense of shame or incompetence, ignore the perceived benefits of their behaviors, and speak in abstract terms they may not yet be able to grasp. Above all, we need to demonstrate our trustworthiness and convey our intention to enable them to move forward propelled by their existing strengths.

This article will discuss the process of building an effective relationship with adolescents and their families. It will focus on applying a strengths-based approach and will cover four key points:

1) Building a trusting relationship
2) Recognizing and building on existing strengths
3) Helping teens develop their own solutions to problems
4) Helping teens develop positive coping strategies to deal with life's inevitable challenges

This article is not meant to offer a comprehensive counseling model, but rather to expose clinicians to an alternative philosophi-

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Goals and Objectives

Goal: To give pediatricians new strategies to effectively interact with and counsel adolescents in the course of everyday practice.

Objectives: After reading this article, the pediatrician will be better prepared to:

- Set the stage for building a positive bond with adolescent patients and their families
- Understand a strengths-based approach for interviewing and counseling teens
- Perform a psychosocial assessment using creative counseling techniques that includes evaluation for risky behaviors
- Establish and maintain trusting and appropriate relationships with families

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Section on Adolescent Health
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cal approach to caring for teens that is based on empirical observation and practice, and grounded in positive youth development and resiliency theories.

BUILDING A TRUSTING RELATIONSHIP

An initial step to uncovering strengths is to create a setting where our adolescent patients can comfortably reveal their experiences, perspectives, and complex emotions. Young people will not, and should not, share intimate details of their lives before they conclude that we are trustworthy. They will withhold information unless they think sharing will benefit them and until they are comfortable that they will not be judged as a person solely on the basis of what they disclose. The effective clinician shows concern about risky behavior in a way that simultaneously communicates respect.

When adolescents remain closed, clinicians "learn" from experience that attempts to connect are often futile. The provider may then be less likely to attempt to use future visits for health promotion and risk reduction. And parents who do not understand that confidentiality is part of a health promotion strategy may not comfortably acquiesce to the evolving confidential relationship between their adolescent and the health professional. For these reasons, it is valuable to spend 3 to 5 minutes at the outset of the office visit to "set the stage" for an effective relationship by briefly addressing everyone's concerns. **(See Table 1)**

The goals of this initial step include making ourselves trustworthy to teenagers and clearly defining the importance of the parents' role in the adolescent-professional-parent relationship. It is ideal to set the stage in the beginning of the initial visit with a parent present because teenagers may be more likely to trust the social contract when parents express agreement. Having parents present in the beginning of the visit also assures that their concerns are known before the visit is focused.

While 3 to 5 minutes may seem burdensome in the context of a busy office visit, we need to set the stage only once, either in the beginning of a relationship with an adolescent patient or during the transition from the parent-centered pediatric visit to the adolescent-centered visit. This effort will be well invested if it increases the yield of the interview, the effectiveness of counseling, and the likelihood that adolescents will be willing to consult with us when they need help to avert a crisis or navigate a challenge. It will also facilitate parental buy-in to a relationship where privacy is honored.

TABLE 1

Essential Points for Setting the Stage

- Adolescents need to learn how to navigate the health care system independently. That process begins by giving their own histories and spending private time with the clinician.
- Private issues will be discussed. The clinician will:
  - Strive to be nonjudgmental
  - Share a commitment of honesty
  - Guarantee privacy (with exceptions to privacy clearly stated)
- Parents have an essential role.
  - They are central members of "the team"
  - They agree that physician/patient privacy may help their teen share and reflect on their behaviors.
  - They are the most important people in their adolescents' lives and will be included as much as is possible and appropriate.
  - They agree that information disclosed to them in a medical setting should be met with strategies for safety, not punishment.
- Recognize and reinforce effective parenting. Credit parental efforts to support and enhance their teen's strengths and/or resilience.

Structuring the Assessment

While each clinician will tailor the introductory conversation to match his or her clinical style, the topics to cover and the reasons for covering them are relatively consistent in most contexts. A guide to these topics is presented below, along with the rationale for addressing each. An italicized script embedded within each section demonstrates how the conversation might flow. We have found that this sequence allows adolescents and parents to become more comfortable with a biopsychosocial approach.

Defining Your Practice Style

Adolescent patients may not see the medical setting as a place to seek help for emotional problems or guidance about behavioral choices. It is helpful to clarify this.

As I see it, a doctor's job is to keep kids healthy, safe, and moving toward a positive future. This means that in addition to working to keep your body healthy, I check in with you on how you're handling stress, your emotional health, and whether or not your behaviors are safe.

Talking About the Flow of the Visit

Underscore the importance of the teen's assuming responsibility for his or her own health without losing sight of the changing, but important, role of parents.

In today's visit, I will ask about why you are here, your health history, and your family's health history. I don't expect that you will have all of the answers, so at the end of every set of questions, I will turn to your parents and we'll both learn from them. After you have shared your concerns for the visit, we'll listen to your parents' concerns. Then I'll ask them to leave the room, and you and I will finish with the check-up. This will give us an opportunity to talk privately. Of course, you can ask me questions at any time.

Considering the Context

Insight into the factors likely to have an impact on your patient's health can be ascertained if you ask the following question, and then listen intently to the patient's response.

During this private time we can talk about all sorts of things. Imagine you were a doctor caring for kids your age. If you wanted to help them stay healthy and safe, what kinds of things would you want to know about?

It is ideal to conduct a full psychosocial screen at every routine visit, but this may not be realistic. The teenager's response to the previous question helps the clinician focus on issues likely to be of greatest concern to the patient.

Acknowledging the Teen's Right to Decide What to Disclose

It is important that teens know that they are in control of what they disclose. This part of the conversation enables the interviewer to demonstrate trustworthiness.

Just because I ask a question doesn't mean that you have to answer it. You have 3 choices. First, you can tell me that you'd rather not talk about it right now. I would really respect that answer. Second, you could lie to me. Because I don't read minds, I would never know, but I wouldn't be able to help you either. The third choice is what I'm hoping for: to create a space safe enough for you to get good solid health information and where you feel comfortable telling me what is going on in your life.

Honesty

Teenagers have ample experience with adults who use scare tactics or threats to manipulate their behavior. They need an adult who will listen, allow them to reflect on their behavior and, when necessary, engage them in a risk-reduction process. If they are taking the chance to be honest, they need to know they will get honest information in exchange. Many adolescents fear that clinicians withhold information and give the full story only to parents.

For me to be able to help you, I need to know what is really going on in your life. That means that I am asking you to be honest. In exchange, I promise to be honest with you – you'll know what I know and even what I don't know. This is a place you'll always be able to get truthful information.

Judgment

Adolescents are unlikely to share information if they believe they will be judged.

I take care of many young people in this community -- teens who do all sorts of things. My job is to help all of them become the best they can be. Sometimes teens tell me about behaviors they know are unsafe and that I wish they weren't doing. I may try to guide them toward safer, wiser behaviors, but I don't judge them as human beings and, of course, I don't punish them. I am honored that they choose to tell me the truth, and I respect their honesty.

Confidentiality

Privacy is at the core of the adolescent-clinician relationship. Adolescents must clearly understand their rights within the medical setting so they can comfortably seek services and guidance. Our choice of language is critical. Be careful about using the word "confidential" because many adolescents interpret that as meaning you intend to have confidence in them. Do not use the word "secret" because it has negative connotations. All adolescents understand the word "privacy." When they worry about lapses of privacy, they are concerned about their parents, teachers, the police, even persons in your front office who may know their neighbors.

Adolescents need to understand the explicit limitations of privacy, which may vary by state. The standard script ("Unless I thought you were going to hurt yourself, hurt someone else, or someone were abusing or hurting you") does not sufficiently clarify limitations or protections. From a teenager's perspective, a health professional thinks cigarettes, unprotected sex, maybe even skipping school could "hurt" them. Therefore, it is important to be clear.

Your information will be kept private. That means I will not tell the people at the front desk, your teachers, your friends, not even your parents, unless I get permission from you first. However, there are exceptions. If I thought your life was in danger because you were thinking of killing yourself, or worried that you were seriously thinking about hurting another person, or if you were being abused or neglected by an adult, I would not want to -- nor would I be able to -- keep your information private. I would work closely with you to get you immediate help. Everything else stays private unless you say otherwise.

The Role of Parents

Parents are not likely to trust the clinician if they feel that they have been excluded. In talking with parents and teens, clinicians should acknowledge that parents are the most important figures in their teens' lives and that brief counseling in a pediatrician's office cannot substitute for ongoing parental guidance. It is also important that parents do not undermine future disclosure by punishing their adolescents for behaviors revealed during an office visit.

Ask the teen directly: *If you and I decided that you might really be in trouble, who could help you the most?* Then, listen silently as you learn about his or her essential support system. While few teens will respond spontaneously by identifying their parents as their primary support system, eventually almost all adolescents will do so.

I'm glad you trust your mom/dad. And although I promise you strict privacy, if I think you might be headed for trouble I may suggest that we work together to figure out the best way to get your parent(s) involved. But, I will never do it without your permission unless your life or someone else's life is in danger.

Then ask the parent: *I'd like us to work together as a team. As a parent, you may need to set up guidelines, or even appropriate rules, to keep your child safe. But can we agree that if something comes up in our visits, your son/daughter would not be punished? The best way for me to help your son/daughter is to team up with you, but at the same time, it's important to understand that teenagers are most likely to come to their doctor, or their parents, to get out of trouble if they can do so without fear of getting into trouble.*

At this point, the clinician can begin the initial history, allowing the adolescent to answer each question to the best of his or her ability. Parents should be invited to comment after their teen has completed each section of the history. When the parents feel that their concerns have been heard, they can be asked to step out for a few minutes to give their child the opportunity to be interviewed and examined alone. Once in private, the clinician can perform the psychosocial assessment. One approach, the SSHADESS mnemonic, is presented in **Table 2.** If younger adolescents prefer that their parents stay in the room, follow their lead, but only perform a limited SSHADESS screen. Instead, use the opportunity to teach and to promote good communication between parents and child about adolescent issues and behaviors. It is likely that they will desire privacy for the next visit.

TABLE 2

SSHADESS: A Strengths Assessment Tool for the Psychosocial Screening

Many clinicians use a standard flow of questioning to assure they cover the major areas of concern in adolescents' emotional and behavioral health. (See resource lists, pp 7, 8). One of the best-known screening tools, HEADSS (Cohen, Mackenzie, and Yates, 1991), has been in use in pediatric practices for 15 years. SHADSSS was a modification (Clark and Ginsburg, 1995) that added questions about violence-related risks. The SSHADESS screen (Ginsburg, 2007) underscores resiliency by opening with questions about strengths before proceeding to environmental context and risks.

Strengths

Begin by allowing adolescents to offer a description of their **S**trengths or interests. Many patients have trouble describing themselves, and find it particularly challenging to praise themselves. If this is the case, ask, *"Well, what makes you proud?"* Some adolescents with a low self-image may still remain at a loss. In this case, try the follow-up question *"Well, what would your good friends say about you?"*

From here, lead into questions about **S**chool, **H**ome, **A**ctivities, **D**rugs/substance use, **E**motions/depression, **S**exuality and **S**afety. Always take care to explore assets as well as potential risks and to allow the teenager the opportunity to offer context. Explore ways in which the young person is contributing to his or her community or school, and notice solid connections with family. Pay attention to healthy behaviors that display creativity or keep your patient emotionally, physically, or spiritually well balanced. Listen for environmental context that can offer a history of resilience or unusual insight.

RECOGNIZING AND BUILDING ON EXISTING STRENGTHS

There are practical advantages to focusing on our adolescent patients' strengths. The risk-based approach, which focuses on negative behaviors, may engender shame. Shame is a barrier to engagement; adolescents may be confused or even angry when their behavior is highlighted out of context.

A person contemplating change is more likely to take action if he or she has confidence in the potential for change. That confidence derives from a deep-seated belief in one's capabilities and is undermined by a fear of failure. Adolescents are not inspired to change or take positive action when equipped only with knowledge that others think they have failed.

Our approach also sets the tone for our interaction. A central tenet of the strengths-based approach is that adolescents live up or down to our expectations. When they know that we respect them and enjoy seeing evidence of their thoughtfulness, or their newfound ability to be self-reflective or gain new insights, they engage in conversation more readily. Teens will be more receptive to health messages offered by someone who believes in their capability to succeed.

Defining success as the absence of risk behaviors conveys low expectations. As ongoing stable adults in their lives, we should consistently hold our adolescent patients to high expectations and continually reinforce the idea that they are individuals prepared to contribute to their families and their communities. Proponents of the youth development and resiliency approaches recognize the destructive potential of risk behaviors, but believe that a positive, strength-based approach will reinforce inherent strengths and help adolescents propel themselves forward.

When we identify risk, it can be too easy to slip into a pattern of assuming these risks reflect the adolescent's life. In doing so, we are often responding to the crises parents present to us. "I know Jake is using drugs, I think it explains his nasty attitude." "I see marks on Katie's arms; she's doing it to herself." Other times, the clinical history reveals 15-year-olds who think a baby will bring instant love, 17-year-olds who think a gun keeps them safe, and 14-year-olds engaging in unprotected sex. Certainly we need to address these problems, but if we focus only on mistakes we lose the opportunity to help teenagers realize that they can do better. We risk losing the

A Strengths-based Approach to Address Risk

When we know something about what an adolescent is doing well, or have seen evidence of emotional depth or resilience, we are prepared to address problems and convey a genuine belief that he or she can do better.

Reflect back to the patient some of his or her positive points.

Listen to the patient until you grasp something authentically positive. This can't be about external trappings; it has to be a genuine strength. When doing this, don't be afraid to tell your patient that you are impressed! Show how you know that he or she can do things well.

In talking to you, I am struck by how deeply you care about your little brother. As tough as things have been, you remain a kind young man committed to making sure your brother has it better than you. And you want to be a counselor so that you can help other kids make it through tough times. Some people are defeated by difficulty, but you seem to be able to use tough times to figure out how to grow stronger.

Pause for a moment

This is an opportunity to let what you have just said sink in and then shift your focus.

Share your concerns

Adolescents appreciate it when adults are worried about them so long as they don't attempt to control them.

I am really worried about you. You're really stressed out and are smoking a lot of marijuana. I am concerned that the marijuana will get in the way of everything you've been working for. Your brother needs you to be successful because you are his role model. I'd hate for anything to mess that up.

Ask permission to address the problem

Adolescents are rarely in control of who tries to guide them. While they may be forced to listen, they will be the ones to decide whether or not they are ready to hear the message.

I would like to talk a bit about marijuana use and maybe some other ways to deal with stress. Is that all right?

Address the problem

Once the adolescent has expressed agreement, the clinician can directly address the risk behavior, and ideally suggest healthy alternatives to worrisome behaviors.

opportunity to inspire them when they quietly become defensive and close themselves off.

An adult committed to building resiliency or strength would address these problems differently. First, we listen for context. A teen may be using drugs in an attempt to obscure or ease her pain. A young girl who desires a baby may need to prove she has the capacity to nurture. Patients may explain that self-mutilation (cutting) allows them to control when, where, and how deeply they experience pain; they are seeking a solution to unbearable pain perhaps so intense that a person with less strength may not have survived at all.

Respectful, reflective, and intent listening, rather than teaching or preaching, allows teens to reveal their strengths. Look beyond the behavior and begin to explore the need that behavior fulfills. Behind most worrisome choices are tales of coping with a stressful world and sometimes even matters of survival. Behind many masks of invincibility are worried children with a limited sense of control over their environments.

Even teens engaging in very worrisome behaviors are almost always doing something in their lives worthy of praise. Listen for demonstrations of resiliency, of overcoming the odds, of genuine kindness or compassion. Explore the young person's dreams and discover how he or she hopes to contribute to the world. Don't take "I don't care" at face value. Many kids who "don't care" or are "lazy" care so deeply that the facade feels more comfortable. When an adolescent tells you of a life filled with risk, appreciate her honesty. When she grasps the connection between her drug use and her stress, note her insight.

If we are to engage rather than alienate teens, we must address risk in a way that enables them to recognize problems themselves and then generate their own solutions.

Adolescents whose competencies are recognized are reassured that we do not view them as failures. The clinician can leverage confidence based upon points of competency to help teens contemplate change and overtake the forces of self-doubt and hopelessness that make negative behaviors seem to be the most viable alternatives. (See **A Strengths-Based Approach to Address Risk**, page 5)

Similarly, parents whose competencies are recognized are more inclined to build on their own strengths. When their children are engaging in risky behaviors or rejecting their love, attention, or authority, parents may feel like failures. Those who have lost faith in their own effectiveness are less likely to offer essential supervision and guidance. They may begin to convey low expectations, undermining their adolescent's resolve. For these reasons, we should be equally committed to recognizing and reinforcing parental strengths.

HELPING TEENS DEVELOP THEIR OWN SOLUTIONS

When we recognize adolescents' existing strengths, we reinforce their ability to make healthy decisions. In parallel, we hope to lower barriers to success by encouraging risk avoidance. However, if we are to engage rather than alienate teens, we must address risk in a way that enables them to recognize problems themselves and generate their own solutions. This means moving beyond only offering information or a lecture.

The traditional lecture starts with a definitive statement about a behavior (essentially, *"Stop that!"*), then presents 3 or 4 reasons to stop, and ends with theoretical examples that show how failing to stop will lead to dire consequences. The speaker presumes that linking potential consequences to each choice will convince adolescents to do the right thing, but teenagers who have no opportunity to explain their choices may instead feel cut off, unheard, and disrespected. More importantly, those who are cognitively unprepared to grasp a complex chain of associations may feel incompetent, confused, frustrated, and even angry. Ultimately, because they may not grasp the potential harm of their behavior and resent what they perceive to be adults' overreactions, they may proceed to prove that the behavior is "no big deal" by doing precisely what we counsel against.

The disconnect between the good intentions with which lectures are delivered and the reality in which they are received may be largely explained by the cognitive differences between adults and adolescents. A typical lecture has an abstract pattern that is obscure to younger adolescents who are still concrete thinkers. Instead of grasping the intended message, they may feel alienated.

When we steer adolescents through real and hypothetical experiences by breaking abstract concepts into concrete, under-

standable steps, they are more likely to independently grasp how their behaviors can lead to unintended consequences. Our concerns can be broken down: "*Could you imagine how A could go to B? Have you ever seen it happen? Tell me about that.*" When that association is understood, proceed with "*Do you see how B might lead to C? Do you know anyone that it happened to?*" Or, "*What kinds of things do you think might make a difference in whether B would lead to C?*" With this approach, we guide them down the path, but they themselves arrive at conclusions they need not resent or rebel against because they have figured them out on their own. They experience their own competence and gain the confidence to take the first steps toward positive behavioral change.

HELPING TEENS DEVELOP POSITIVE COPING STRATEGIES

When a behavior of concern is viewed out of its environmental and emotional context, it is often approached in a manner that causes the young person to feel ashamed. An embarrassed adolescent is unlikely to be receptive to guidance. On the contrary, his or her sense of incompetence is highlighted and level of stress is increased. Because stress drives many worrisome behaviors, our interventions may do harm.

We must move beyond telling adolescents what not to do, and instead reinforce the positive steps they can take. Adolescents often engage in unhealthy behaviors as a means to deal with a stressful world. Stress causes discomfort and adolescents reach for coping strategies to lessen those uncomfortable feelings. There are positive and negative ways of coping, but the terms "positive" and "negative" are not meant to describe effectiveness. They convey value judgments.

Negative coping strategies offer short term quick-fixes, but become destructive. They generate and perpetuate a dangerous cycle and sometimes lead to addictions. Many concerning adolescent behaviors sometimes serve as coping strategies (eg, running away, substance use, sexual activity, violence, self-mutilation, gang affiliation, teen pregnancy, or disordered eating).

Rather than presenting a few convincing facts and then telling our patients to "stop that," we can help our patients realize — without shame — that their behaviors may very well be attempts to manage stressful life circumstances.

Many people find it difficult to describe themselves as sad, nervous, or fearful. However, "stress" remains an acceptable term that allows youth to acknowledge their feelings. When we view adolescent behaviors in the context of their efforts to decrease stress, we avoid subtly accusing them of being careless, reckless, or thoughtless. Instead, we are able to guide them to develop a repertoire of positive strategies to serve as lifelong stress-reduction tools.

Because every person has unique needs and interests, the clinician can guide patients to develop individual plans. A stress-reduction plan may include such strategies as breaking large problems into manageable pieces and knowing when to let things go. It may also feature physical, spiritual, meditative, and creative outlets.

It can be difficult, in a busy practice, to find time to develop a stress management plan with every patient. Many will be able to develop their own plan with limited guidance. See http://aap.org/stress for a 10-point interactive theory-based stress reduction tool that adolescents can navigate independently to create plans tailored to their unique needs, experiences, and interests.

We will never be able to prevent worrisome behaviors altogether because some are enjoyable and experimentation is a part of adolescence, but we can decrease young people's reliance on dangerous quick fixes when we guide them toward positive strategies to manage stress.

ONLINE RESOURCES

Karen J. Pittman, Peter L. Benson, Richard F. Catalano, and J. David Hawkins are associated with some of the best-known research in positive youth development; some have been writing on this topic for more than 30 years. Peter Benson's 40 Developmental Assets, *for example, is an excellent guide for anyone hoping to foster healthy, responsible, and caring behavior.*

The Forum for Youth Investment
Karen J. Pittman, executive director.
www.forumfyi.org.

Search Institute
Peter L. Benson, PhD, president
www.search-institute.org/assets

Social Development Research Group
Richard F. Catalano, PhD., director;
J. David Hawkins, founding director.
http://depts.washington.edu/sdrg

CONCLUDING THOUGHTS

Health professionals are ideally positioned to monitor adolescent patients for worrisome behaviors and guide them toward healthier choices. Adolescents are more likely to disclose behaviors of concern if we make an effort to demonstrate that we are trustworthy. When we help teens develop their own solutions to problems, we reinforce their sense of competence and help them gain confidence to move in the right direction. When we see even troublesome behaviors in the context of what they are also doing well, we diminish shame and encourage young people to build on their existing strengths. Finally, when we help young people develop a repertoire of positive coping strategies to manage life's inevitable challenges, we help them find the courage to avoid dangerous quick-fixes.

Physicians, parents, schools, and communities should send a consistent message to our youth: that our goals for them are far higher than the absence of negative behaviors. We must recognize and celebrate the strengths of adolescents so that they know we expect them to successfully lead us into the future.

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The Parent's Role in the Adolescent Health Care Visit

During adolescence, children learn to navigate the world on their own. Adolescents still require supervision but also need to take on more responsibility. These years can be a scary time for parents, who worry that their children may make mistakes along the journey to adulthood.

The health care setting is an important, safe place for your child to learn to function independently. Our goal is to help adolescents become comfortable and competent in seeking health care. With your help, we can assure that by the time they leave your home they will be able to:

- Know when and how to seek health care
- Talk to a clinician (doctor, nurse, or physician's assistant) on their own
- Give their own medical and family health history
- Advocate for their own health needs

To help children learn to deal with clinicians independently, we suggest that parents allow their teens to take the lead when they visit the doctor. You can do this by:

- Allowing your child to express his/her concerns and medical history
- Listening carefully for points he or she might have missed
- And then adding your thoughts after they are done

This will give your child the opportunity to learn from you about how to get points across to clinicians. We do not expect that your child will become an overnight expert in working with us. Adolescents build skills every year so they will be able to function independently by the time they leave home. In late adolescence, most teens are ready to see their physicians on their own, but as parents, you will always have the opportunity to express your concerns.

Now that your child is becoming more independent, health care visits will routinely include a private conversation with the health care provider that will focus on emotional and behavioral health. During this time, we will ask personal questions and guarantee privacy. Adolescents are told we will not keep information private if their life is in immediate danger. *We know parents are the most important people in children's lives and will always encourage your child to share information with you.*

Frequently asked questions

Why do adolescents need privacy?

Many teenagers don't open up to their parents mainly because of how much they love their parents and worry about disappointing them. Private time with a clinician allows them to get guidance from an adult who they know cares about them but whom they worry less about disappointing. If adolescents trust us and talk with us, we can do a much better job of helping you to keep your son or daughter healthy.

What can I do to make it more likely that my child will come to me first with problems?

There is nothing more important to children than knowing that their parents will listen and remain supportive even if they are in trouble. When they need help, adolescents need to know that their parents will respond to problems with guidance, not punishment. Our goal is always to include you. Children are more likely to tell us that they do not need privacy if their parents make it clear that they will help with any problem that comes up in our visit, and that helping will not involve punishment.

We can do our best work keeping your child moving toward a positive future when he or she knows our office is a place to get out of trouble *without* worrying about getting into trouble! We are here as a positive resource for you as you help your child navigate adolescence.

This patient education sheet is distributed in conjunction with the March 2007 issue of *Adolescent Health Update*, published by the American Academy of Pediatrics.

What Is New in the New CDC STD Treatment Guidelines?

by Gale R. Burstein, MD, MPH, FAAP and Kimberly A. Workowski, MD, FACP, FIDSA

On August 4, 2006, the United States Centers for Disease Control and Prevention (CDC) published updated guidelines for treatment of sexually transmitted diseases. This edition of Hot Topics summarizes updated recommendations for (1) the diagnosis and prevention of genital herpes simplex virus (HSV) infection, and (2) genital *Chlamydia trachomatis* and *Neisseria gonorrhoeae* screening and retesting.

Genital HSV Infection

Type-specific HSV serologic assays may be useful when clinicians encounter recurrent genital symptoms or atypical symptoms with negative HSV cultures. They are also useful when there is a clinical diagnosis of genital herpes without laboratory confirmation or a partner with genital herpes. Some specialists believe that HSV serologic testing should be included in a comprehensive sexually transmitted infections (STI) evaluation among persons with multiple sex partners, human immunodeficiency virus (HIV) infection, and among men who have sex with men (MSM).

Current HSV-specific glycoprotein G2 (HSV-2) and glycoprotein G1 (HSV-1) assays should be specifically requested when HSV serology is performed. These include HerpeSelect™-1 or -2 enzyme-linked immunosorbent assay (ELISA) immunoglobulin G (IgG), HerpeSelect™ 1 and 2 Immunoblot IgG (Focus Technology, Inc., Herndon, Virginia), and HSV-2 ELISA (Trinity Biotech USA, Berkeley Heights, New Jersey). Test sensitivities of these vary from 80%-98% and specificities are ≥96%. Beware of older assays that do not accurately distinguish HSV-1 fromHSV-2 antibody.

Prevention.

In addition to consistent condom use and the avoidance of sexual activity during recurrences, treatment with valacyclovir 500 mg daily decreases the transmission rate in discordant heterosexual couples where the source partner has a history of genital HSV-2 infection. Suppressive antiviral therapy probably reduces transmission when used by persons with multiple partners and by those who are HSV-2 seropositive without a history of genital herpes, but these groups were not evaluated.

Chlamydia trachomatis and *Neisseria gonorrhoeae*

In the United States, chlamydial genital infection is the most frequently reported infectious disease and gonorrhea the second most common bacterial STI. Prevalences of both are highest in persons ≤25 years. In females, most *C. trachomatis* and *N. gonorrhoeae* infections are asymptomatic, yet they can lead to pelvic inflammatory disease (PID), ectopic pregnancy, and infertility. Annual *C. trachomatis* screening of all sexually active females aged ≤25 years is recommended. Evidence is insufficient to recommend routine *C. trachomatis* and *N gonorrhoeae* screening in sexually active young men. However, male chlamydia screening may be appropriate in clinics with high chlamydia prevalence. *C. trachomatis* nucleic acid amplification tests (NAATs) are the most sensitive tests for endocervical, urethral, and urine specimens and some are also cleared for vaginal swab specimen testing. All *C. trachomatis* NAATs offer combination *N. gonorrhoeae* testing, but product inserts for each NAAT vendor must be carefully examined to assess current indications for FDA-cleared specimen types.

Chlamydia and gonorrhea reinfection rates are high in females – in some studies up to 13%-16% within 4 months posttreatment. Since repeat infections may confer a higher risk for PID and other complications, providers are encouraged to advise ALL chlamydia- and gonorrhea-infected females to be retested approximately 3 months after treatment (or whenever they next seek medical care). Although there is limited evidence on the benefit of retesting males for chlamydial and gonococcal infection, some specialists suggest retesting approximately 3 months after treatment. If concerns exist that sex partners will not seek evaluation and treatment, the provision of antibiotic therapy (either a prescription or medication) by heterosexual male or female patients to their partners should be considered, but may not be feasible because of logistical or legal barriers.

References

1. Sexually Transmitted Diseases Treatment Guidelines, 2006. Centers for Disease Control and Prevention. *MMWR.* 2006;55(RR11):1-94
2. Corey L, Wald A, Patel R, et al. Once-daily valacyclovir to reduce the risk of transmission of genital herpes. 2004;350:11-20
3. Legal Status of Expedited Partner Therapy (EPT). Available at: www.cdc.gov/std/ept/legal/default.htm. Accessed January 18, 2007

Gale R. Burstein, MD, MPH, FAAP, is medical director of Epidemiology and Surveillance, STD & TB Control at the Erie County Department of Health, and a clinical assistant professor of pediatrics at Women and Children's Hospital, Buffalo, NY.

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Hot Topics in Adolescent Medicine is designed to keep readers of *Adolescent Health Update* apprised of the latest developments in adolescent care. Please forward your comments to Sheryl A. Ryan, MD, FAAP, editor, (sheryl.ryan@yale.edu).

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American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

TRAUMA & RESILIENCE

AN ADOLESCENT PROVIDER TOOLKIT

ADOLESCENT HEALTH WORKING GROUP

AHWG

THE ADOLESCENT HEALTH WORKING GROUP (AHWG)

History: The AHWG was formed in 1996 by a group of adolescent health providers and advocates concerned about the lack of age-appropriate health services for young people in the city of San Francisco.

Vision: All youth have unimpeded access to high quality, culturally competent, youth friendly health services.

Mission: Support and strengthen the network of providers working to improve adolescent health.

Core Functions:

1) Develop tools and trainings that increase providers' capacity to effectively serve youth/young adults.

2) Advocate for policies that increase access to care and utilization of youth/young adult services.

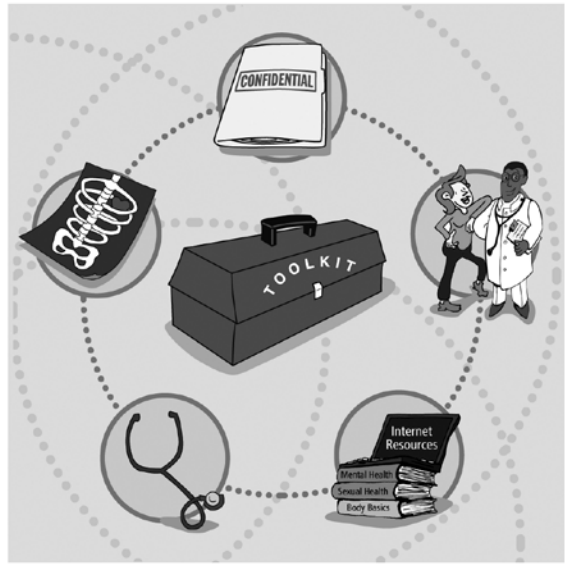
3) Convene stakeholders and coordinate linkages across systems to improve information sharing, networking, and referrals for youth/young adult services.

Fiscal Sponsor: The AHWG is a project of the Tides Center.

Additional Info: www.ahwg.net

AHWG

www.ahwg.net



Illustrations by Jordan Zaini, 17

THE AHWG ADOLESCENT PROVIDER TOOLKIT SERIES

The toolkit consists of five modules:

1. Adolescent Health 101 (2003)
2. Body Basics (2004)
3. Understanding Minor Consent and Confidentiality in CA (2003, 2010)
4. Behavioral Health (2007)
5. Sexual Health (2010)
6. Trauma & Resilience (2013)

Designed for busy providers, each module addresses a complexity of issues through accessible, user-friendly resources including screening and assessment tools, evidence based best practices and promising approaches, and health education handouts for youth/young adults and parents/caregivers. The toolkit series, developed locally, has been distributed and utilized by providers nation wide. Accompanying training has also been developed and delivered locally and regionally to health plans, community clinics, and educators.

For more information on AHWG resources, training, and events, please visit:

www.ahwg.net.

TRAUMA & RESILIENCE

Trauma & Resilience, the sixth module of the AHWG Adolescent Provider Toolkit Series, was created in response to a continued demand among providers for resources focused on the intersections of health and violence.

The Trauma & Resilience toolkit module is designed to:

1) Encourage paradigm shifts from:
   - Trauma to resilience
   - Deficits to assets
   - Oppression to empowerment
   - Individuals to systems

2) Increase communication and collaboration among different service sectors and systems of care including: health, education, juvenile justice, workforce development, human services, housing, and youth/young adult development programs.

The Trauma & Resilience toolkit module is designed for:

- All levels of youth/young adult service providers, from front line staff, to clinicians, to administrators.

Youth Handouts

- Handouts specifically designed for youth/young adults are starred and underlined in the Table of Contents.
- Youth handouts may also be useful with parents/caregivers and community members, as deemed appropriate by providers, and in conjunction with supportive services.
- Youth handouts are intended to enhance communication, education, and support for youth/young adults, parents/caregivers, and community members, NOT replace it.

Capacity Building

The AHWG recognizes that this work is dependent on the involvement of providers, youth/young adults, and parents/caregivers across all sectors and systems. As a result, the AHWG will continue to focus its efforts on capacity building among health providers to meet the unique needs of youth and young adults, in addition to assisting with the development of supports for providers across other sectors and systems. Please contact the AHWG to inquire about possible collaboration opportunities. Current contact info can be accessed at www.ahwg.net

Suggested Citation

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- Instituto Familiar de la Raza
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Dedicated to:

Jeff & Lyla St. Andrews

CONTENTS

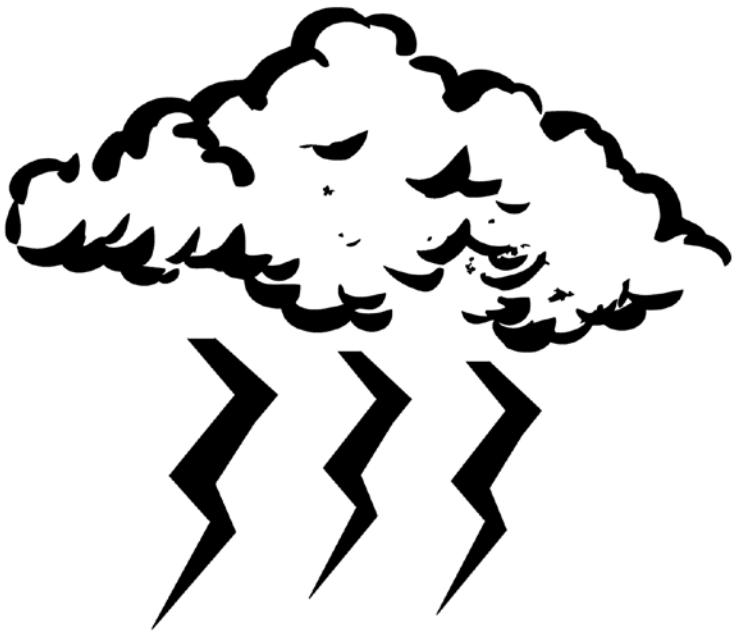
1. TRAUMA

2. RESILIENCE

3. CARE

▲ FOR YOUTH: Youth handouts specifically designed for youth/young adults are starred and underlined. Youth handouts may also be useful with parents/caregivers and community members, as deemed appropriate by providers, and in conjunction with supportive services. Youth handouts are intended to enhance communication, education, and support for youth/young adults, parents/caregivers, and community members, NOT replace it.

TRAUMA



KEY FACTS ON TRAUMA

THE TRAUMA EQUATION: TRAUMA = THE SUM OF EVENTS, EXPERIENCE, AND EFFECTS (1)

EVENTS

+ Events or circumstances may include the actual or extreme threat of physical or psychological harm or the severe withholding of resources for healthy development.
+ Events may occur once or repeatedly over time.

EXPERIENCE

+ An event may be experienced as traumatic by one individual and not another.
+ The experience may be influenced by cultural beliefs and the developmental stage of the individual.

EFFECTS

+ Adverse effects may occur immediately or over time.
+ Effects may include physical, mental, emotional, cognitive, behavioral, social, and spiritual challenges.
+ Individuals may not recognize the connection between effects and events.

TRAUMA IN THE CONTEXT OF COMMUNITY

- Trauma occurs in the context of community including:

  1) Neighborhoods: shared identity, culture, ethnicity, socioeconomic status, or experience, and 2) Organizations: place of work, learning, or worship.
- How a community responds to individual trauma sets the foundation for the impact of the traumatic events, experience, and effects.
- Communities that provide understanding, support, and self-determination may facilitate the healing and recovery process for the individual.
- Communities that avoid, overlook, or misunderstand the impact of trauma may often re-traumatize the individual and interfere with the healing process.

TRAUMA AND THE COLLECTIVE COMMUNITY EXPERIENCE

- Similar to an individual, a community may be subjected to a threatening event, share an experience of the event, and have adverse prolonged effects.
- Resulting trauma is often transmitted from one generation to the next in a pattern referred to as historical, community, or intergenerational trauma.
- Communities can collectively experience trauma similarly to the ways in which individuals respond to trauma.

TRAUMA-INFORMED CARE IS AS MUCH ABOUT SOCIAL JUSTICE AS IT IS ABOUT HEALING

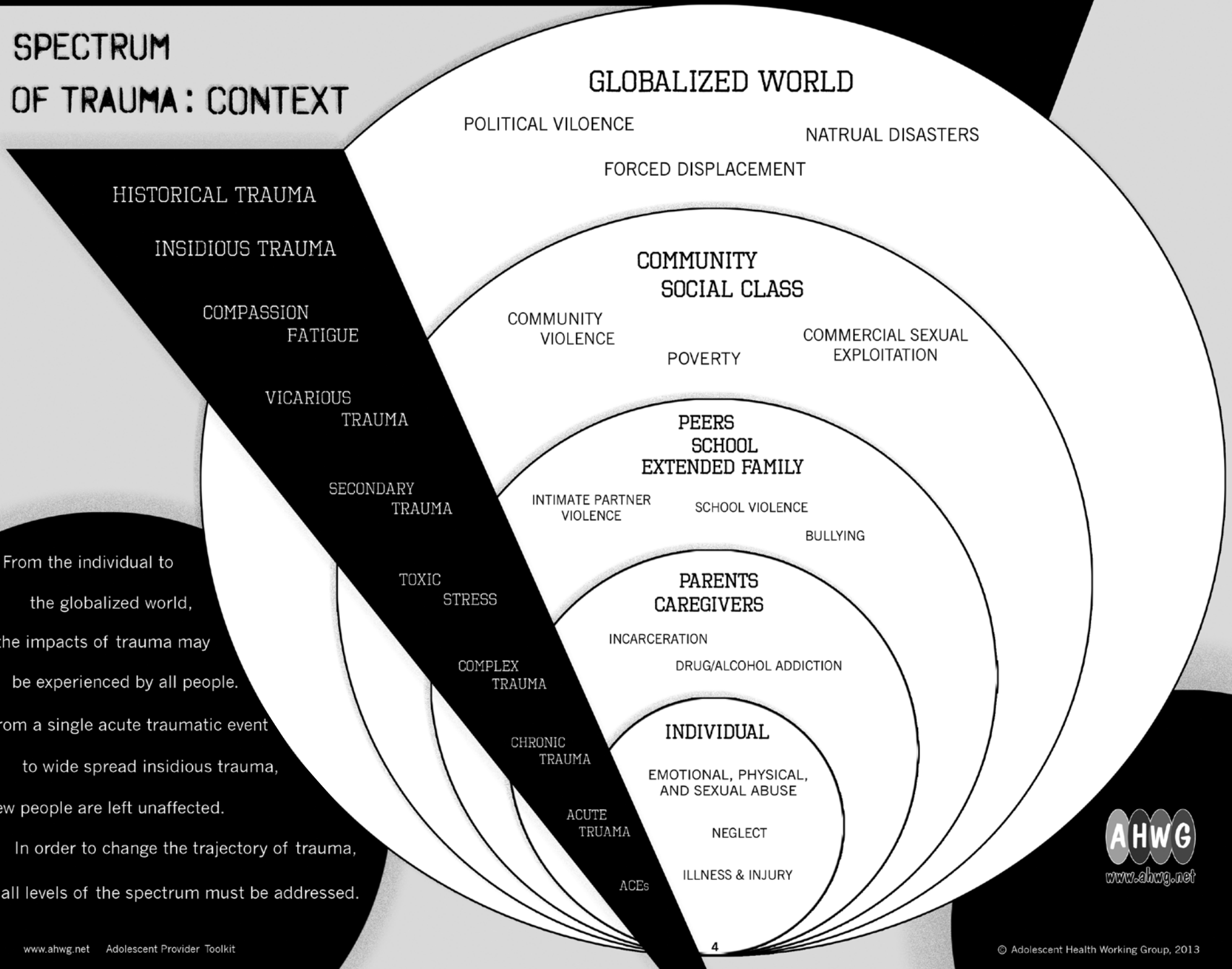
- The earlier in life trauma occurs, the more damaging the consequences may be.
- Prevention and early intervention of traumatic events and resulting consequences are critical.
- People are resilient and can recover from even severe trauma.
- With services, support, and resilience, healing is possible.

Sources: 1. Substance Abuse and Mental Health Services Administration (SAMHSA). 2012. Trauma Definition Working Draft. http://www.samhsa.gov/traumajustice/traumadefinition/index.aspx.
2. National Association of State Mental Health Program Directors (2012, September). Changing Communities, Changing Lives. Report prepared for the Substance Abuse and Mental Health Services Administration's National Center for Trauma-Informed Care. Alexandria, VA: (Joan Gillece, Project Director; Andrea Blanch, Author).

SPECTRUM OF TRAUMA : TERMINOLOGY

TERM	DEFINITION	EXAMPLES
Adverse Childhood Exeriences (ACEs) (2) 	Single or multiple traumatic exposures and/or events experienced during childhood.  	• Child physical abuse, sexual abuse, or emotional abuse • Child physical or emotional neglect • Mentally ill, depressed, or suicidal person in the home • Drug addicted or alcoholic family member • Witnessing domestic violence against the mother • Loss of a parent to death or abandonment in the context of divorce or separation • Incarceration of any family member
Acute Trauma (3)	A single, time-limited traumatic event.	• Physical maltreatment, abuse, assault • Sexual maltreatment, abuse, assault, rape • Emotional abuse, psychological maltreatment • Neglect • Natural disasters, war, terrorism, political violence • Kidnapping, human trafficking, commercial sexual exploitation • Forced displacement (refugees, political asylees) • Intimate partner violence, community violence, school violence • Bullying, harassment • Injuries, accidents • Illness, painful medical procedures • Severely impaired caregiver • Abandonment, betrayal of trust by primary caregiver • Traumatic loss, bereavement • Accumulated burdens of family's severe economic hardship • Homelessness
Chronic Trauma (3)	Multiple traumatic exposures and/or events over extended periods of time.	
Complex Trauma (4) **and Polyvictimization** (5)	Children/adolescent's experiences of multiple traumatic events and the impact of exposure to these events, often occurring within the care giving system.	
Toxic Stress (6)	Adverse experiences that lead to strong, frequent, or prolonged activation of the body's stress response system.	
Secondary Trauma (7) **and Vicarious Trauma** (8)	Exposure to the trauma of others as experienced, realized, or imagined by providers, family members, partners, or friends in close contact with traumatized individual.	
Compassion Fatigue (9)	Cumulative physical, emotional, and psychological effects of exposure to traumatic stories or events when working in a helping capacity.	
Insidious Trauma (10) **and Historical Trauma** (11)	Collective, massive group trauma and compounding forms of multiple oppressions including discrimination based on race, economic status, gender, sexuality, and immigration status, as experienced over extended periods of time, within societies and institutions.	• Colonialism • Genocide • Slavery • Poverty • Internment

SPECTRUM OF TRAUMA: CONTEXT



From the individual to the globalized world, the impacts of trauma may be experienced by all people. From a single acute traumatic event to wide spread insidious trauma, few people are left unaffected. In order to change the trajectory of trauma, all levels of the spectrum must be addressed.

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TRAUMA INEQUITIES

SOCIAL DETERMINANTS OF HEALTH

- Youth living in poverty are most likely to be exposed to trauma experiences, both at home and in the community.
- Roughly three times as many African-American, Hispanic, and American Indian/Alaska Native children live in poverty compared to White and Asian-American children.
- Poverty is a greater problem for minority ethno-cultural groups that have historically been subjected to political and cultural trauma in the US and in their families' countries of origin.
- Asian-American children and their families who are immigrants from impoverished and violence-torn countries are more vulnerable to violence as a result of racism and the scars of historical trauma.
- Other groups at high risk for exposure to violence in childhood include: urban and rural poor, tribal communities, lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth and adults; children and parents with physical disabilities or mental illness and addictions; and homeless individuals and families.(12)

CRADLE TO PRISON PIPELINE

- African American boys born in 2001 have a 1 in 3 chance of being imprisoned in thier lifetimes.(13)
- Latino boys born in 2001 have a 1 in 6 chance of being imprisoned in their lifetimes.(13)
- Arrest rates of trauma-exposed youth are up to 8 times higher than community samples of same-age peers.(14,15)
- Being abused or neglected as a child increases the likelihood of arrest as a juvenile by 59%.(16)
- 70%-92% of incarcerated girls report sexual, physical, or severe emotional abuse in childhood.(17,18)
- 70% of youth in residential placement have some type of past traumatic experience, with 30% having experienced frequent and/or injurious physical and/or sexual abuse.(19)

SUBSTANCE ABUSE

- Trauma increases the risk of developing substance abuse, and substance abuse increases the likelihood that adolescents will experience trauma.
- Up to 59% of youth with Post Traumatic Stress Disorder (PTSD) subsequently develop substance abuse problems.
- In surveys of adolescents receiving treatment for substance abuse, more than 70% had a history of trauma exposure. (20)
- Traumatic stress/PTSD may make it more difficult for adolescents to stop using, as exposure to reminders of traumatic events have been shown to increase drug cravings in people with co-occurring trauma and substance abuse. (20)
- Youth who are already abusing substances may be less able to cope with traumatic events as a result of the functional impairments associated with problematic use.
- Youth with both substance abuse and trauma exposure show more severe and diverse clinical problems than do youth who have been afflicted with only one of these problems.
- When trauma and substance abuse are treated separately, youth are more likely to relapse and revert to previous maladaptive coping strategies.(20)

TRAUMA EVIDENCE

ADVERSE CHILDHOOD EXPERIENCES (ACEs) STUDY (2)

Kaiser Permanente and Centers for Disease Control and Prevention, 1998

The Study:

17,000 mostly white, college-educated, employed adults were screened for 10 prominent childhood traumatic experiences as part of their routine health care at Kaiser. Participants received one point for each type of trauma.

The Results:

- 70% of the 17,000 people experienced at least one type of trauma, resulting in an "ACE score" of one; 87% of those had more than one.
- ACE scores of 4 or more resulted in four times the risk of emphysema or chronic bronchitis; over four times the likelihood of depression; and 12 times the risk of suicide.
- ACE scores were also directly correlated with early initiation of smoking and sexual activity, adolescent pregnancy, and risk for intimate partner violence.
- Eighteen states have since conducted ACE surveys with similar results.

NATIONAL SURVEY OF CHILDREN EXPOSED TO VIOLENCE (NATSCEV) (21)

Department of Justice and Centers for Disease Control and Prevention, 2009

The Study:

Over 4,500 children and youth from birth to age 17 were surveyed in the first attempt to measure the cumulative exposure to violence over a young person's lifetime, including violence in the home, school, and community.

The Results:

- Over 60% of children were exposed to violence in a year.
- Nearly half (46%) experienced a physical assault.
- 30% witnessed an assault in their community.
- 20% witnessed an assault in their family.
- 6% experienced sexual victimization.
- Over 38% were victimized two or more times.
- Over 10% were victimized five or more times.

Trauma Screening and Re-traumatization: Why Answering Questions About Trauma May Be Less Distressing Than Waiting in Line At The Bank (22)

University of New Mexico, 2012

The Study:

Over 500 undergraduate college students were randomly assigned to take a standardized intelligence test or to answer questions about trauma and sex, for two hours.

The Results:

- Participants who completed the trauma/sex survey reported slightly higher negative emotion on average than the intelligence-test participants, but the difference was very small, and the average level of negative emotion in both conditions was very low.
- Participants who completed the trauma/sex survey reported more positive emotion, more personal insight, less boredom, and less mental exhaustion.
- Participants in both conditions reported that the two-hour study was significantly less distressing than all 15 ordinary life events, including getting a paper cut, or waiting in line for 20 minutes at a bank.

COMPASSION FATIGUE:

INCLUDES: 1) PROVIDER BURNOUT, AND 2) SECONDARY TRAUMA/VICARIOUS TRAUMA

BURNOUT

- State of physical, emotional and mental exhaustion caused by long-term involvement in emotional demanding situations. (23)
- Associated with feelings of hopelessness and difficulties in dealing with work or doing one's job effectively. (24)

SECONDARY TRAUMA/VICARIOUS TRAUMA

- Work-related, secondary exposure to extremely or traumatically stressful events.
- Can be the result of the exposure of helpers to experiences of clients, in tandem with empathy experienced for clients. (25)
- Can be sudden and acute.

VICARIOUS TRAUMATIZATION

- A transformation in the helper's inner experience, as a result of empathic engagement with traumatized clients and their traumatic experiences, coupled with a commitment or responsibility to help. (26)

SIGNS AND SYMPTOMS OF VICARIOUS TRAUMATIZATION (27)

General Symptoms

- Numbing
- Social withdrawl
- Nightmares
- Despair and hopelessness
- No time or energy for self
- Disconnection from loved ones
- Increased sensitivity to violence

Internal Transformations

1. A Shifted Frame of Reference: Identity, spirituality, and worldview (e.g. questions goodness of others, loss of hope or optimism).
2. Diminished Self-Capacities: Capacity to tolerate strong emotion, and maintain connection with self and others.
3. Alterations in Sensory and Memory Experiences: Client's memories become incorporated into helper's memory.
4. Disrupted Psychological Needs: Safety, trust, esteem, intimacy, control.
5. Lessened Ego Resources/Internal Resources: Ability to establish and maintain boundaries, ability to strive for personal growth, ability to be introspective, awareness of psychological needs, clear cognitive processing, perspective, empathy, and sense of humor.

Impact on Organizations

- Colleagues experiencing vicarious trauma may treat each other with acts of unkindness, discourtesy, sabotage, infighting, lack of cohesiveness, scape-goating, bullying, and criticism among colleagues within and between affiliated organizations, a phenonmenon referred to as "horizontal violence." (28)

Assessment

- The Professional Quality of Life Scale (ProQOL) is the most commonly used measure of the negative and positive affects of helping others who experience suffering and trauma. The ProQOL has sub-scales for compassion satisfaction, burnout, and compassion fatigue. See: http://www.proqol.org/ProQol_Test

Source: Joyce Dorado, (2013). Self-Care for Educators: Coping with Stress in School. UCSF Healthy Environment and Response to Trauma in Schools (HEARTS), Child and Adolescent Services, Dept. of Psychiatry, University of California, San Francisco.

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE (PROQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

3. _____
6. _____
12. _____
16. _____
18. _____
20. _____
22. _____
24. _____
27. _____
30. _____

Total: _____

The sum of my Compassion Satisfaction questions is	So My Score Equals	And my Compassion Satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score

You Wrote	Change to
	5
2	4
3	3
4	2
5	1

*1. _____ = _____
*4. _____ = _____
8. _____
10. _____
*15. _____ = _____
*17. _____ = _____
19. _____
21. _____
26. _____
*29. _____ = _____

Total: _____

The sum of my Burnout Questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Secondary Traumatic Stress Scale

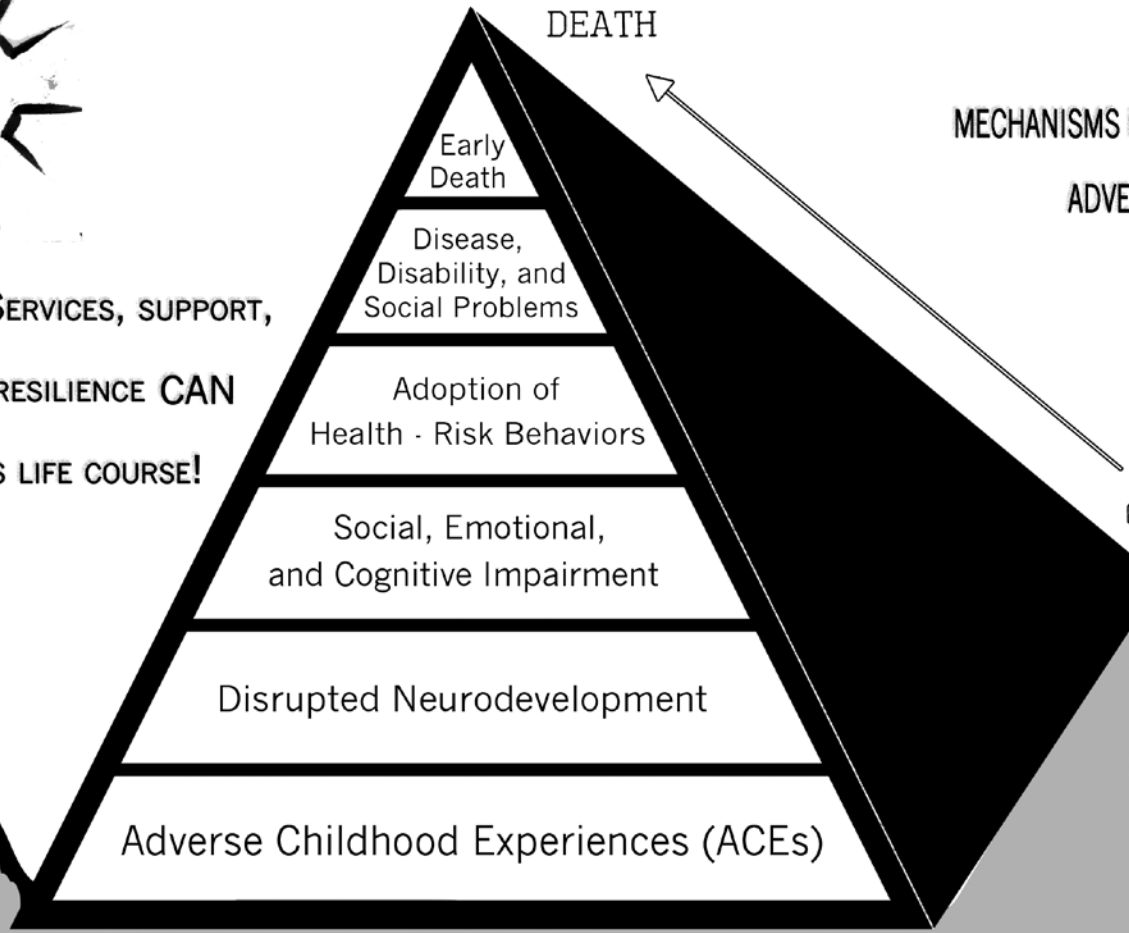
Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

2. _____
5. _____
7. _____
9. _____
11. _____
13. _____
14. _____
23. _____
25. _____
28. _____

Total: _____

The sum of my Secondary Trauma questions is	So My Score Equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

ACEs Pyramid[29]: The Origins of Risk Factors



MECHANISMS BY WHICH

ADVERSE CHILDHOOD EXPERIENCES (ACEs)

INFLUENCE HEALTH AND WELL-BEING

THROUGHOUT THE LIFE-SPAN

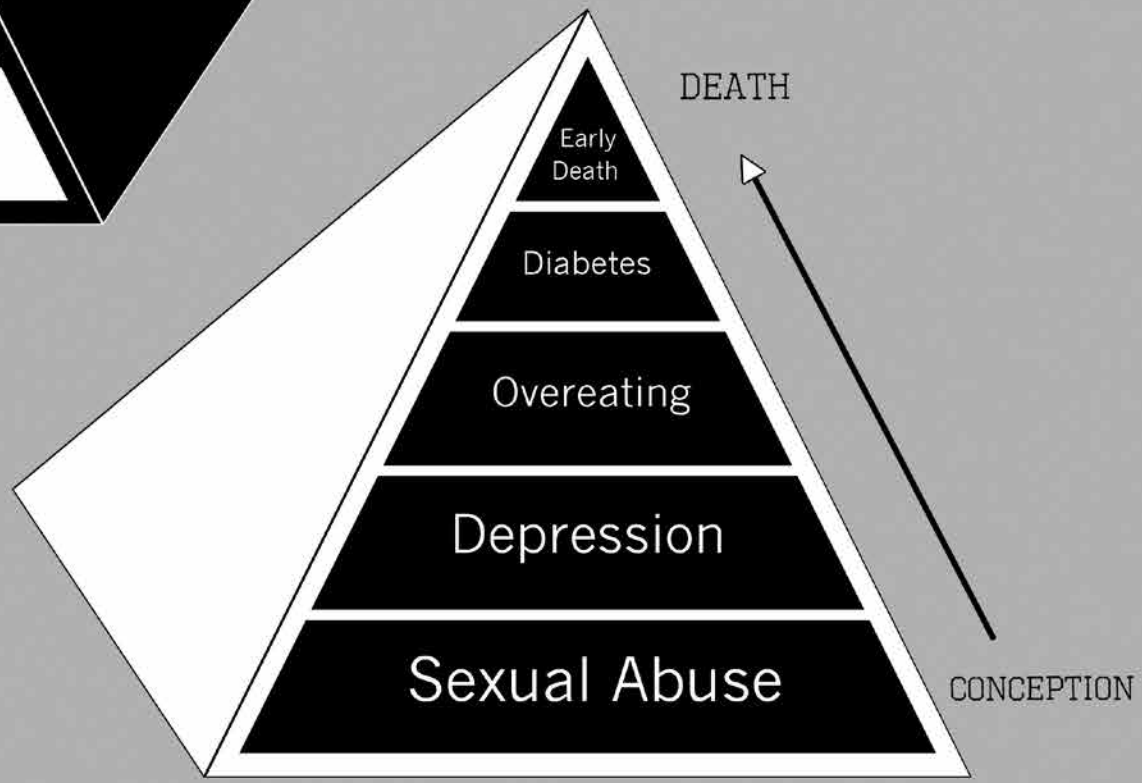
SERVICES, SUPPORT,

AND RESILIENCE CAN

CHANGE THIS LIFE COURSE!

ACEs Pyramids:[29]

REAL LIFE SCENARIOS



SERVICES, SUPPORT, AND RESILIENCE CAN CHANGE THIS LIFE COURSE!

HEALTH RISK BEHAVIORS:

MALADAPTIVE COPING STRATEGIES FOR ADVERSE CHILDHOOD EXPERIENCES (ACEs)

SEEKING TO COPE

- Health risk behaviors underlying adult diseases may actually function as effective coping strategies during adolescence.(30)
- Health risk behaviors may not be viewed by youth as the problem, they might be the youth's solution, a way to feel safe, reduce tension, and feel better, OR the youth may be completely unaware of what drives ACE-related behaviors, compulsions, or reactions.
- Dismissing maladaptive coping strategies as "bad habits" or "self destructive" misses their function.
- Maladaptive coping strategies need to be investigated, linked to previous ACEs, and adapted into positive coping strategies and behaviors.

ADVERSE CHILDHOOD EXPERIENCES (ACES) (2)

Abuse of Child Under Age 18

- Emotional Abuse
- Physical Abuse
- Sexual Abuse

Neglect of Child Under Age 18

- Physical neglect
- Emotional neglect

Household Environment

- Alcohol or drug user in home
- Chronically depressed, emotionally disturbed, or suicidal household member
- Mother treated violently
- Imprisoned household member
- Parents separated or divorced

EFFECTS OF TRAUMA AND RELATED HEALTH RISK BEHAVIORS(2)

Neurobiologic Effects of Trauma

- Disrupted neuro-development
- Difficulty controlling anger, rage
- Hallucinations
- Depression
- Anxiety
- Panic reactions
- Multiple (6+) somatic problems
- Sleep problems
- Impaired memory
- Flashbacks
- Dissociation

Health Risk Behaviors Used to Ease the Pain of Trauma

- Smoking
- Physcial inactivity
- Eating disorders
- Alcoholism
- Drug abuse
- Suicide attempts
- Self injury
- 50+ sexual partners
- Repitition of original trauma
- Perpetrate interpersonal violence

LONG-TERM CONSEQUENCES OF UNADDRESSED TRAUMA (ACES)(2)

Disease and Disability

- Cancer
- Ischemic heart disease
- Chronic lung disease
- Chronic emphysema
- Asthma
- Liver disease
- Severe obesity
- Skeletal fractures
- Poor self rated health
- Sexually transmitted infections
- HIV/AIDS

Serious Social Issues

- Homelessness
- Commercial sex work
- Delinquency, violence, criminal activity
- Inability to sustain employment
- Re-victimization: domestic violence, rape, bullying
- Long-term use of multiple human service systems
- Compromised ability to parent
- Intergenerational trauma

Source: Ann Jennings, PhD. www.theannainstitute.org

ADVERSE CHILDHOOD EXPERIENCES (ACEs) 10 QUESTION SCREENING TOOL

The ACEs 10 Question Screening Tool is an abbreviated version of the ACEs Family Health History Questionnaires and Health Appraisal Questionnaires available at: http://www.cdc.gov/ace/questionnaires.htm

A comprehensive list of validated youth trauma screening and assessment tools are maintained on the NCTSN Measures Review available at: http://www.nctsn.org/resources/online-research/measures-review

FINDING YOUR ACEs SCORE

WHILE YOU WERE GROWING UP, DURING YOUR FIRST 18 YEARS OF	Circle	One	If YES Enter 1
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	
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	
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	
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	
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	
6. Were your parents ever separated or divorced?	Yes	No	
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	
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	Yes	No	
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?	Yes	No	
10. Did a household member go to prison?	Yes	No	
NOW ADD UP YOUR "YES" ANSWERS. THIS IS YOUR ACEs SCORE.			

Source: http://acestoohigh.com/got-your-ace-score/

ADOLESCENT BRAIN DEVELOPMENT

Brain Function: Manages cognitive, emotional, behavioral, and physical functioning.

Brain System: Made up of interconnecting systems that go from least complex (brainstem: mediates heart rate) to most complex (frontal lobe: the main decision maker of the brain).

Brain Growth: 2 major growth spurts: 1) in the womb, and 2) between childhood and adolescence.

IMPORTANT: Brain development is **NOT** complete until mid to late 20's.

Neurons that Fire Together Wire Together (Hebb's Rule): Brain neurons synapse (i.e. connect with other neurons) or change (chemically and structurally) in response to signals from the environment (experiences) and create memories (cognitive, emotional, behavioral, and physical). The more often neural connections are made, the stronger these connections become.

Synaptic Pruning: During adolescence, the brain begins to break down the least used synapses, or connections and strengthens those most used.

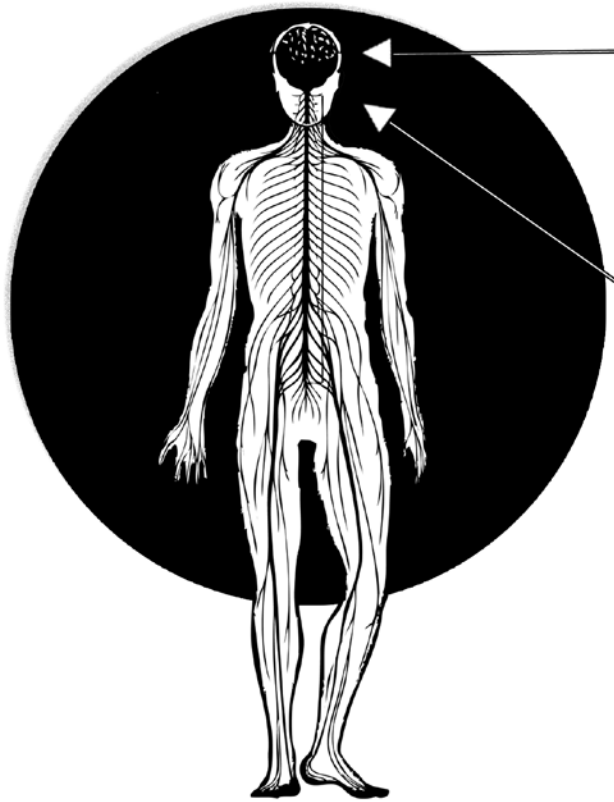
MOST COMPLEX

Frontal Lobe

Abstract Thought
Concrete Thought
Affiliation
Attachment
Sexual Behavior
Emotional Reactivity
Motor Regulation
Arousal
Appetite
Sleep
Blood Pressure
Heart Rate
Body Temperature

Brainstem

LEAST COMPLEX



HIGHER FUNCTIONS

Frontal Lobe

Learning Brain: thinking, planning, decision-making
Impulse and behavior control
Undergoing development in youth ages 10-24

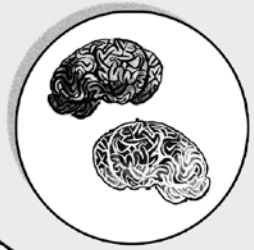
LOWER FUNCTIONS

Brainstem

Survival Brain: flight, flight, or freeze
Emotion-driven processing
Heavily relied on by youth

Source: Dorado, J. 2013. Promoting School Success for Students Who Have Experienced Complex Trauma: Creating Trauma-Sensitive School Environments. Healthy Environments and Response to Trauma in Schools (HEARTS), University of California San Francisco (UCSF).

SURVIVAL BRAIN VS. LEARNING BRAIN



ALARM SYSTEM: We all have normal alarm systems in our brain/body that lets us know when we are under threat and mobilizes us to fight, flight, or flee threat. When youth experience continuous threats/trauma, the brain/body is put into a chronic state of fear, activating the "survival brain" (mid/lower areas of the brain). This can create an overactive alarm system in the developing brain. A youth's brain/body that develops within the context of trauma can be more easily triggered into "survival brain" by "trauma reminders" or "triggers" even when there is no actual threat. (32,33)

TRAUMA TRIGGERS: Can activate the "survival brain," causing youth to react as though a "there and then" experience (previous traumatic event) is happening "here and now" (in current reality).

Common triggers include:

- Unpredictability
- Sudden changes or transitions
- Loss of control
- Sensory overload
- Feeling vulnerable
- Rejection
- Loneliness
- Confrontation
- Intimacy
- And even praise or positive attention

When youth are in a triggered state, they may not be able to access higher functions of the frontal lobe ("learning brain"). At this time, verbal warnings of consequences, or making demands on the higher "learning brain" (i.e. asking them to explain their decision-making process), may escalate the situation.

DE-ESCALATION: Youth in a triggered state need help to calm down from "there and then" triggers and become more present in "here and now" reality, (in which there may be no actual threat). Feelings of safety and control must be re-established in order for youth to think more clearly.

Strategies include:

- Noticing signs of distress
- Connecting with the youth
- And then re-directing behavior through providing reasonable choices/options for alternative activities/circumstances
- After youth is calm, discussion about what happened can take place and if necessary, consequences can be determined

The long-term goal is NOT to turn off the brain/body alarm system, as the alarm is needed to detect ongoing/real threats. The goal is to increase the alarm's accuracy so that it doesn't turn on unnecessarily.

BRAIN PLASTICITY: Patterned, repetitive activities can help the brain to re-wire and organize itself into more healthy functioning. Activities may include: music, movement, drumming, yoga, deep breathing, mindfulness, and positive, nurturing interactions with trustworthy adults and peers. (32)

Source: Dorado, J. 2013. Promoting School Success for Students Who Have Experienced Complex Trauma: Creating Trauma-Sensitive School Environments. Healthy Environments and Response to Trauma in Schools (HEARTS), University of California San Francisco (UCSF).

NEUROBIOLOGICAL RESPONSE SYSTEMS

STRESS RESPONSE: POSITIVE, TOLERABLE, OR TOXIC (33)

POSITIVE STRESS RESPONSE

- Normal and essential part of healthy development.
- Includes brief increases in heart rate and mild elevations in hormone levels.

Examples: Attending a new school; going out with new friends.

TOLERABLE STRESS RESPONSE

- Activates the mind/body alarm system as a result of more severe, longer-lasting difficulties.
- If activation is time-limited and buffered by relationships with caring adults who help youth to adapt, the brain and other organs may recover from possible damaging effects.

Examples: Loss of a loved one; natural disaster; frightening injury.

TOXIC STRESS RESPONSE

- Can occur when youth experiences strong, frequent, and/or prolonged adversity.
- Without adequate adult support, prolonged activation of the stress response system can disrupt the development of brain architecture and other organs
- Risk for stress-related disease and cognitive impairment is increased well into adulthood.

Examples: Physical or emotional abuse; chronic neglect; caregiver substance abuse or mental illness; exposure to violence; accumulated burdens of severe family economic hardship.

SURVIVAL RESPONSE: FIGHT, FLIGHT, OR FREEZE (34-36)

FIGHT

- Youth struggle to regain or hold on to power, especially when feeling coerced.

Youth often mislabeled as: Non-compliant or combative.

FLIGHT

- Youth disengages or runs away and "checks out" emotionally.

Youth often mislabeled as: Uncooperative or resistant.

FREEZE

- Youth gives in to those in positions of power; does not, or is unable to "speak up."

Youth often mislabeled as: Passive or unmotivated.

CHRONIC TRAUMA

AFFECTS THE WHOLE YOUTH

EMOTIONAL

Terror/fear
Sadness
Shock
Loss of pleasure from activities
Despair
Emotional numbering
Hypersensitivity
Helplessness
Depression
Irritability
Guilt
Grief
Phobias
Anger

PHYSICAL

Sleep disturbance
Startle response
Somatic complaints
Insomnia
Impaired immune response
Gastrointestinal problems
Decreased appetite
Hyperarousal
Decreased libido
Headaches
Fatigue

INTERPERSONAL & BEHAVIORAL

Aggression
Regression in behavior
Crying easily
Risk taking
Social withdrawl
Change in eating patterns
Alienation
Avoiding trauma reminders
Tantrums
School impairment
Refusal to go back to school
Increased relationship conflict
Vocational impairment
Isolation

CONGNITIVE

Worry
Nightmares
Confusion
Disbelief
Memory impairment
Impaired decision making ability
Impaired concentration
Decreased self-efficancy
Self blame
Distortion
Decreased self-esteem
Intrusive thoughts/ memories

POST TRAUMATIC STRESS DISORDER (PTSD)

Post Traumatic Stress Disorder (PTSD) is the leading diagnosis available in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-IV) for post traumatic symptoms among youth and adults. (37)

PTSD is an important diagnosis, however it is limited by the following: (38)

- Originally developed for and is most relevant to adults, not children/youth.
- More often captures symptoms of single/acute traumatic events, not complex/chronic traumatic events.
- Focuses on the individual.

PTSD A: Stressor

The person has been exposed to a traumatic event in which both of the following have been present:

1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.
2. The person's response involved intense fear, helplessness, or horror. Note: in children, it may be expressed instead by disorganized or agitated behavior.

PTSD B: Intrusive Recollection

The traumatic event is persistently re-experienced in at least one of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.

Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

2. Recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content.
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: In children, trauma-specific reenactment may occur.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

PTSD C: Avoidant/Numbing

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
3. Inability to recall an important aspect of the trauma.
4. Markedly diminished interest or participation in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect (e.g., unable to have loving feelings).
7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

PTSD D: Hyper-Arousal

Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least two of the following:

1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hyper-vigilance.
5. Exaggerated startle response.

PTSD E: Duration

Duration of the disturbance (symptoms in B, C, and D) is more than one month.

PTSD F: Functional Significance

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify If: Acute: If duration of symptoms is less than three months; Chronic: if duration of symptoms is three months or more; With or Without delay onset: Onset of symptoms at least six months after the stressor.

BEYOND PTSD: DEVELOPMENTAL TRAUMA DISORDER

Developmental Trauma Disorder is a proposed diagnosis for the upcoming fifth edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-V) to capture more developmentally appropriate post traumatic symptoms specific to children/youth. (38)

Developmental Trauma Disorder Includes:

1) Child/youth specific and developmentally appropriate symptoms. 2) Complex/chronic trauma symptoms. 3) Role of impaired caregiving systems.

AFFECTIVE AND PHYSIOLOGICAL DYSREGULATION Impaired arousal regulation	• Inability to modulate, tolerate, or recover from extreme affect states (e.g fear, anger, shame) including prolonged and extreme tantrums, or immobilization. • Disturbances in regulation of bodily functions (e.g. sleeping, eating, and elimination; over-reactivity or under-reactivity to touch and sounds; disorganization during routine transitions). • Decreased awareness or dissociation of sensations, emotions, and bodily states. • Impaired capacity to describe emotions or bodily state.
ATTENTIONAL AND BEHAVIORAL DYSREGULATION Impaired attention, learning, and coping mechanisms	• Preoccupation with threat, or impaired capacity to perceive threat, including misreading of safety and danger cues. • Impaired capacity for self-protection, including extreme risk-taking or thrill-seeking. • Maladaptive attempts at self-soothing (e.g. rocking, other rhythmical movements, compulsive masturbation). • Habitual (intentional, automatic, or reactive) self-harm. • Inability to initiate or sustain goal-directed behavior.
SELF AND RELATIONAL DYSREGULATION Impaired sense of personal identity and involvement in relationships	• Intense preoccupation with safety of caregiver or loved ones, or difficulty tolerating reunion with them after separation. • Persistent negative sense of self (e.g. self-loathing, helplessness, worthlessness, ineffectiveness, or defectiveness). • Extreme and persistent distrust, defiance or lack of reciprocal behavior in close relationships with adults or peers. • Reactive physical or verbal aggression toward peers, caregivers, or other adults. • Inappropriate (excessive or promiscuous) attempts to get intimate contact (including but not limited to sexual or physical intimacy) or excessive reliance on peers or adults for safety and reassurance. • Impaired capacity to regulate empathic arousal (e.g. lack of empathy for, or intolerance of distress in others, or excessive responsiveness to the distress of others).
FUNCTIONAL IMPAIRMENT School, family, peer group, legal, health, and work impairments	• **School:** Under-performance, non-attendance, disciplinary problems, drop-out, failure to complete degree/credentials, conflict with school personnel, learning disabilities or intellectual impairment that cannot be accounted for by neurological or other factors. • **Family:** Conflict, avoidance/passivity, running away, detachment and surrogate replacements, attempts to physically or emotionally hurt family members, non-fulfillment of responsibilities within family. • **Peers:** Isolation, deviant affiliations, persistent physical or emotional conflict, avoidance/passivity, involvement in violence or unsafe acts, age inappropriate affiliations or style of interaction. • **Legal:** Arrests/recidivism, detention, convictions, incarceration, violation of probation/court orders, increasingly severe offenses, crimes against other persons, disregard or contempt for the law or for conventional moral standards. • **Health:** Physical illness or problems that cannot be fully accounted for, involving digestive, neurological, sexual, immune, cardiopulmonary, proprioceptive, sensory systems, severe headaches (including migraine), or chronic pain/fatigue. • **Work:** Youth involved in, seeking, or referred for employment, volunteer, or job training show disinterest in work/vocation, inability to get or keep jobs, persistent conflict with co-workers or supervisors, under-employment in relation to abilities, failure to achieve expectable advancements.

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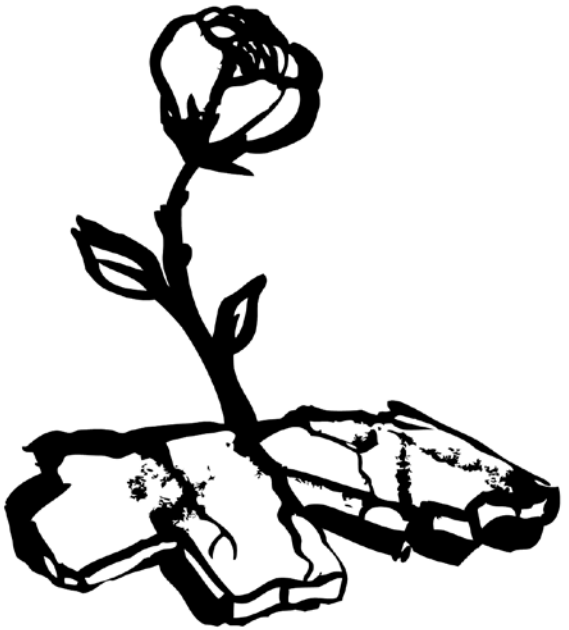
RESILIENCE



SPECTRUM OF RESILIENCE

RESILIENCE

- The positive capacity to cope, adjust to, or recover from stress and negative life events; includes personality traits, social skills, and responses that enable thriving in the face of adversity. (1-5)

- All people are born with resilience; it can be nurtured and recaptured if lost.

- Factors can be internal characteristics such as individual talents, energies, strengths, and constructive interests; or external influences like family support, adult role models outside the family, high expectations within the community, and the availability of creative activities.

POSTTRAUMATIC GROWTH

- 30%-90% of people affected by a serious crisis describe some type of posttraumatic growth. (8)

- Posttraumatic growth includes changes in perception of self, the improvement and deepening of relationships with others, a heightened compassion for others, an increased ability for expressing emotions, and an ability to find meaning in the trauma experienced.

VICARIOUS RESILIENCE/ (6) COMPASSION SATISFACTION (7)

- Compassion satisfaction includes the pleasure from being able to do one's work well, helping others through work, positive feelings about colleagues, and contributing to the work setting or greater good of society.

- Vicarious resilience is the process in which workers in helping professions may experience positive influences, such as hope and increased self-efficacy, through their work with trauma survivors.

RESILIENCE TRUMPS ACEs

ADVERSE CHILDHOOD EXPERIENCE (ACEs)

- ACEs are NOT a life sentence and they are NOT set in stone.
- There ARE ways to lessen the effects of ACEs.

RESILIENCE

- Responsive caregiving provided to youth from trusted adults can moderate the effects of early stress and neglect associated with ACEs.
- Building resilience can counter the effects of ACEs and help lead youth to more effective, productive, and healthy adulthoods.

BUILDING BLOCKS

- Resilience building blocks include simple actions, responses, and attitudes.
- Each block can look small and simple, but together form a solid foundation on which youth and adults can build the capacity to thrive, even when life poses inevitable hardships, challenges, and disappointments.

Adverse Childhood Experiences (ACEs)

- Sexual abuse
- Physical abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Loss of a parent/caregiver
- Witnessing family violence
- Incarceration of a family member
- Drug addicted or alcoholic family member
- Mentally ill, depressed, or suicidal family member

Source: Resilience Trumps ACEs (copyright). Children's Resilience Initiative. www.resiliencetrumpsaces.org

RESILIENCE BUILDING BLOCKS

FOR ADULTS

- Model appropriate behavior
- Model problem solving skills
- Set clear expectations and rules
- Establish consequences
- Teach youth self-discipline and responsibility
- Assign chores to give youth responsibility
- Have regular check-ins with youth
- Let youth know they are loved
- Let youth know you are available to help
- Help youth express their feelings
- Help youth develop problem-solving skills
- Help youth appreciate cultural and ethnic heritage
- Give youth choices
- Respect youth's ability to make decisions
- Allow youth's experience of success and failure

FOR YOUTH AND ADULTS

- Hope, trust, and a sense of belonging
- Attachment to a caring adult
- Ability to express feelings and calm oneself
- Learn to sense triggers that create negative behaviors and accept ownership of behaviors
- Learn responsibility, problem solving, and decision making
- Learn to ask for help and accept help
- Learn to show appreciation and empathy
- Learn to self-advocate and develop self-esteem
- Develop friendships and share something important
- Develop a sense of control
- Work as a team and give back to the community
- Master a skill and experience success

POSTTRAUMATIC GROWTH

Posttraumatic growth does NOT mean that pain or fear from trauma go away. Posttraumatic growth means that individuals are able to find meaning in the trauma, learn more about themselves in the process, and find opportunities to apply increased self-knowledge to making healthy life choices.

REQUIREMENTS FOR POSTTRAUMATIC GROWTH:(9)

A safe environment

- Since feelings of extreme danger and vulnerability are inherent to most traumatic experiences, establishing feelings of safety for youth is necessary before beginning to process the experience.

Listening without trying to solve

- Youth may feel angry or scared and express a variety of emotions in order to make sense of an experience.
- Caring adults must resist the urge to "make it all better," which may come from personal needs to make intense feelings more tolerable.

Recognizing and highlighting growth or changed perspective:

- Making note and commenting on a youth's new insights can help reinforce positive growth.

Reframing growth and opportunity

- There is a tendency to say that a traumatic experience caused growth. It may be more helpful to reframe and say that trauma didn't cause the growth but created an opportunity for growth.

Referrals for counseling, if appropriate

- Many youth don't know about, are afraid of, or have heard negative experiences about mental health services, however counseling can be a useful tool for youth in making sense out of life

POSTTRAUMATIC GROWTH INCLUDES:

- Changes in one's perception of self.
- Improvement and deepening of one's relationships with others.
- Heightened compassion for others.
- Increased ability to express emotions.

TIPS FOR POSTTRAUMATIC GROWTH: (10)

- Support appropriate interpersonal skills.
- Promote affect regulation (e.g. practicing coping skills such as self-soothing or distraction).
- Support autonomous decision-making and independent functioning.
- Foster spirituality through exploration of beliefs, attitudes and faith.
- Emphasize ability to make changes in the course of life.
- Nurture a clear and positive identity, encouraging identity exploration, and integrating different parts of self.
- Foster hope, belief in the future, goal-setting, and envisioning future plans.
- Recognize positive behavior, and celebrating healthy behavioral changes.
- Provide opportunities for pro-social involvement by creating time or space for positive interaction and community support.
- Establish pro-social norms by not tolerating destructive behavior, and normalizing positive interactions and healthy coping.

Source: Providing Trauma Informed Care for Homeless Youth: A Supervisor's Guide. Hollywood Homeless Youth Partnership. http://hhyp.org/download-material-2/

40 DEVELOPMENTAL ASSETS® FOR ADOLESCENTS (AGES 12-18)

Search Institute® has identified the following building blocks of healthy development—known as Developmental Assets®—that help young people grow up healthy, caring, and responsible.

EXTERNAL ASSETS

SUPPORT

1. Family support—Family life provides high levels of love and support.
2. Positive family communication—Young person and her or his parent(s) communicate positively, and young person is willing to seek advice and counsel from parents.
3. Other adult relationships—Young person receives support from three or more nonparent adults.
4. Caring neighborhood—Young person experiences caring neighbors.
5. Caring school climate—School provides a caring, encouraging environment.
6. Parent involvement in schooling—Parent(s) are actively involved in helping young person succeed in school.

EMPOWERMENT

7. Community values youth—Young person perceives that adults in the community value youth.
8. Youth as resources—Young people are given useful roles in the community.
9. Service to others—Young person serves in the community one hour or more per week.
10. Safety—Young person feels safe at home, school, and in the neighborhood.

BOUNDARIES AND EXPECTATIONS

11. Family boundaries—Family has clear rules and consequences and monitors the young person's whereabouts.
12. School Boundaries—School provides clear rules and consequences.
13. Neighborhood boundaries—Neighbors take responsibility for monitoring young people's behavior.
14. Adult role models—Parent(s) and other adults model positive, responsible behavior.
15. Positive peer influence—Young person's best friends model responsible behavior.
16. High expectations—Both parent(s) and teachers encourage the young person to do well.

CONSTRUCTIVE USE OF TIME

17. Creative activities—Young person spends three or more hours per week in lessons or practice in music, theater, or other arts.
18. Youth programs—Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in the community.
19. Religious community—Young person spends one or more hours per week in activities in a religious institution.
20. Time at home—Young person is out with friends "with nothing special to do" two or fewer nights per week.

INTERNAL ASSETS

COMMITMENT TO LEARNING

21. Achievement Motivation—Young person is motivated to do well in school.
22. School Engagement—Young person is actively engaged in learning.
23. Homework—Young person reports doing at least one hour of homework every school day.
24. Bonding to school—Young person cares about her or his school.
25. Reading for Pleasure—Young person reads for pleasure three or more hours per week

POSTIVE VALUES

26. Caring—Young person places high value on helping other people.
27. Equality and social justice—Young person places high value on promoting equality and reducing hunger and poverty.
28. Integrity—Young person acts on convictions and stands up for her or his beliefs.
29. Honesty—Young person "tells the truth even when it is not easy."
30. Responsibility—Young person accepts and takes personal responsibility.
31. Restraint—Young person believes it is important not to be sexually active or to use alcohol or other drugs.

SOCIAL COMPETENCIES

32. Planning and decision making—Young person knows how to plan ahead and make choices.
33. Interpersonal Competence—Young person has empathy, sensitivity, and friendship skills.
34. Cultural Competence—Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.
35. Resistance skills—Young person can resist negative peer pressure and dangerous situations.
36. Peaceful conflict resolution—Young person seeks to resolve conflict nonviolently.

POSITIVE IDENTITY

37. Personal power—Young person feels he or she has control over "things that happen to me."
38. Self-esteem—Young person reports having a high self-esteem.
39. Sense of purpose—Young person reports that "my life has a purpose."
40. Positive view of personal future—Young person is optimistic about her or his personal future.

ASSETS EVIDENCE

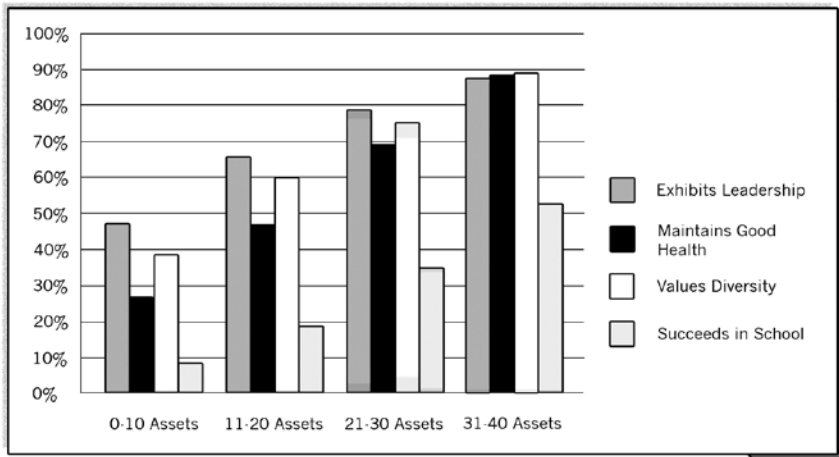
WHAT ARE THEY?

- Assets are common sense positive experiences and qualities that help influence choices young people make and help them become caring, responsible, successful adults.
- Based in youth development, resiliency, and prevention research, with proven effectiveness. (11)

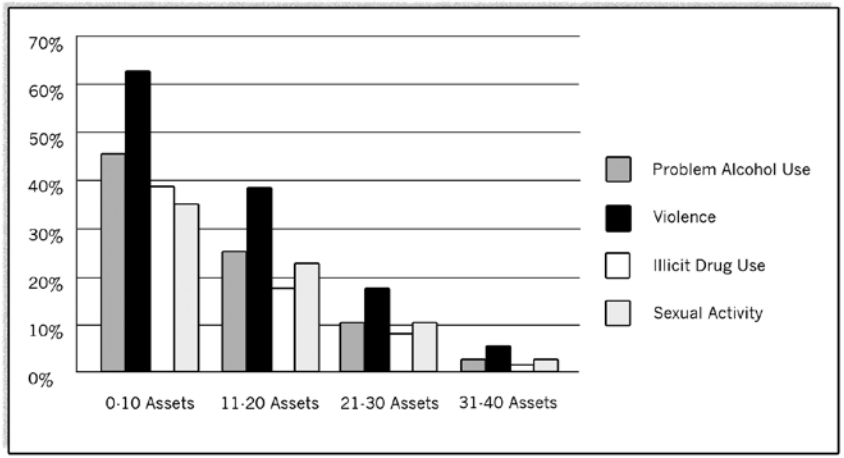
WHO NEEDS THEM?

- Studies of more than 2.2 million young people consistently show that the more assets young people have, the less likely they are to engage in a wide range of high-risk behaviors and the more likely they are to thrive. (11)
- Research has proven that youth with the most assets are least likely to engage in four different patterns of high-risk behavior, including problem alcohol use, violence, illicit drug use, and sexual activity.
- The same kind of impact is evident with many other problem behaviors, including tobacco use, depression and attempted suicide, antisocial behavior, school problems, driving and alcohol, and gambling.

ASSETS PROMOTE POSITIVE ATTITUDES AND BEHAVIORS



ASSETS PROTECT YOUTH FROM HEALTH RISK BEHAVIORS



THE POWER OF ASSETS

- The positive power of assets is evident across all cultural and socioeconomic groups of youth.
- In addition to protecting youth from negative behaviors, having more assets increases the chances that young people will have positive attitudes and behaviors. (11)

Source: Search Institute (copyright). http://www.search-institute.org/developmental-assets

DEVELOPMENTAL ASSETS PROFILE

Self-Report for Ages 11-18

NAME / ID: _____ **TODAY'S DATE:** Mo: _____ Day:_____ Yr:_____

SEX: ☐ Male ☐ Female **AGE:** _____ **GRADE:**_____ **BIRTH DATE:** Mo:_____ Day:_____ Yr:_____

RACE/ETHNICITY (Check all that apply): ☐ American Indian or Alaska Native ☐ Asian

☐ Black or African American ☐ Hispanic or Latino/Latina ☐ Native Hawaiian or Other Pacific Islander

☐ White ☐ Other (*please specify*):

INSTRUCTIONS: Below is a list of positive things that you might have in *yourself, your family, friends, neighborhood, school, and community*. For each item that describes you **now or within the past 3 months**, check if the item is true:

Not At All or Rarely **Somewhat or Sometimes** **Very or Often** **Extremely or Almost Always**

If you do not want to answer an item, leave it blank. But please try to answer all items as best you can.

Not At All or Rarely	Somewhat or Sometimes	Very or Often	Extremely or Almost Always	I . . .
☐	☐	☐	☐	1. Stand up for what I believe in.
☐	☐	☐	☐	2. Feel in control of my life and future.
☐	☐	☐	☐	3. Feel good about myself.
☐	☐	☐	☐	4. Avoid things that are dangerous or unhealthy.
☐	☐	☐	☐	5. Enjoy reading or being read to.
☐	☐	☐	☐	6. Build friendships with other people.
☐	☐	☐	☐	7. Care about school.
☐	☐	☐	☐	8. Do my homework.
☐	☐	☐	☐	9. Stay away from tobacco, alcohol, and other drugs.
☐	☐	☐	☐	10. Enjoy learning.
☐	☐	☐	☐	11. Express my feelings in proper ways.
☐	☐	☐	☐	12. Feel good about my future.
☐	☐	☐	☐	13. Seek advice from my parents.
☐	☐	☐	☐	14. Deal with frustration in positive ways.
☐	☐	☐	☐	15. Overcome challenges in positive ways.
☐	☐	☐	☐	16. Think it is important to help other people.
☐	☐	☐	☐	17. Feel safe and secure at home.
☐	☐	☐	☐	18. Plan ahead and make good choices.
☐	☐	☐	☐	19. Resist bad influences.
☐	☐	☐	☐	20. Resolve conflicts without anyone getting hurt.
☐	☐	☐	☐	21. Feel valued and appreciated by others.
☐	☐	☐	☐	22. Take responsibility for what I do.
☐	☐	☐	☐	23. Tell the truth even when it is not easy.
☐	☐	☐	☐	24. Accept people who are different from me.
☐	☐	☐	☐	25. Feel safe at school.

PLEASE TURN OVER AND COMPLETE THE BACK.

Note: The term "Parent(s)" means 1 or more adults who are responsible for raising you.

Not At All or Rarely	Somewhat or Sometimes	Very or Often	Extremely or Almost Always	
				I AM . . .
☐	☐	☐	☐	26. Actively engaged in learning new things.
☐	☐	☐	☐	27. Developing a sense of purpose in my life.
☐	☐	☐	☐	28. Encouraged to try things that might be good for me.
☐	☐	☐	☐	29. Included in family tasks and decisions.
☐	☐	☐	☐	30. Helping to make my community a better place.
☐	☐	☐	☐	31. Involved in a religious group or activity.
☐	☐	☐	☐	32. Developing good health habits.
☐	☐	☐	☐	33. Encouraged to help others.
☐	☐	☐	☐	34. Involved in a sport, club, or other group.
☐	☐	☐	☐	35. Trying to help solve social problems.
☐	☐	☐	☐	36. Given useful roles and responsibilities.
☐	☐	☐	☐	37. Developing respect for other people.
☐	☐	☐	☐	38. Eager to do well in school and other activities.
☐	☐	☐	☐	39. Sensitive to the needs and feelings of others.
☐	☐	☐	☐	40. Involved in creative things such as music, theater, or art.
☐	☐	☐	☐	41. Serving others in my community.
☐	☐	☐	☐	42. Spending quality time at home with my parent(s).
				I HAVE . . .
☐	☐	☐	☐	43. Friends who set good examples for me.
☐	☐	☐	☐	44. A school that gives students clear rules.
☐	☐	☐	☐	45. Adults who are good role models for me.
☐	☐	☐	☐	46. A safe neighborhood.
☐	☐	☐	☐	47. Parent(s) who try to help me succeed.
☐	☐	☐	☐	48. Good neighbors who care about me.
☐	☐	☐	☐	49. A school that cares about kids and encourages them.
☐	☐	☐	☐	50. Teachers who urge me to develop and achieve.
☐	☐	☐	☐	51. Support from adults other than my parents.
☐	☐	☐	☐	52. A family that provides me with clear rules.
☐	☐	☐	☐	53. Parent(s) who urge me to do well in school.
☐	☐	☐	☐	54. A family that gives me love and support.
☐	☐	☐	☐	55. Neighbors who help watch out for me.
☐	☐	☐	☐	56. Parent(s) who are good at talking with me about things.
☐	☐	☐	☐	57. A school that enforces rules fairly.
☐	☐	☐	☐	58. A family that knows where I am and what I am doing.

THANK YOU FOR COMPLETING THIS FORM.

ATTACHMENT, SELF-REGULATION, AND COMPETENCY (ARC)[12]

ARC: A Conceptual framework and core intervention principles for working with youth who have experienced multiple and/or prolonged traumas. Can be used in: 1) Clinical work with youth, 2) Provider team meetings, and 3) Administrative review of agency policies and procedures.

ATTACHMENT: The capacity to form and maintain a healthy emotional bond with another person as a source of mutual comfort, safety, and caring.

SELF-REGULATION: Developing and maintaining the ability to identify, express, and modulate feelings such as frustration, anger, and fear.

COMPETENCY: Mastering the developmental tasks of adolescence and developing the ability to plan and organize for the future. Areas of competency include: judgment, impulse control, planning, prioritizing tasks, organizing, insight, empathy, and decision-making. Competency also includes specific life skills such as: hygiene, literacy, budgeting and banking, shopping and cooking, transportation, safety planning, time management, and the ability to be assertive.

QUESTIONS FOR CLINICAL WORK WITH YOUTH AND PROVIDER TEAM MEETINGS

ATTACHMENT

- What is known about the quality and consistency of the youth's early child caregiver experiences?
- What quality of relationships does the youth form with peers?
- How does the youth relate to adults, program staff, and authority figures?

SELF-REGULATION

- What does it look like when the youth is experiencing unpleasant feelings (i.e. frequency, intensity, and recovery time)?
- What kinds of situations trigger unpleasant feelings?
- What methods does the youth use to calm down?

COMPETENCY

- Is the youth able to think realistically and with sound judgment about the past, present and future?
- Is the youth able to problem solve, organize/prioritize time, and plan ahead?
- What specific skills does the youth possess and what skills does the youth still need to acquire?

QUESTIONS FOR ADMINSTRATIVE REVIEW OF AGENCY POLICIES AND PROCEDURES

How do agency policies, procedures, and culture support:

- Youth's positive self-regard and ATTACHMENT to the program, peers, providers, family, and community?
- Youth's ability to learn and practice appropriate SELF-REGULATION skills?
- Youth's development of new COMPETENCIES and skills?

NEXT STEPS: After reviewing agency strengths and challenges in each area, providers and administrators can decide how to improve agency support in the three key areas. Often times, small, low or no cost efforts can make significant improvements in creating healing environments for youth.

EXAMPLES:

ATTACHMENT

- Create structured and predictable environments by establishing rituals and routines, and showing unconditional respect and acceptance.

COMPETENCY

- Create opportunities for youth to positively engage with peers, adults, and community members.

SELF-REGULATION

- Create a safe space for youth experiencing intense emotions by training providers to help youth accurately identify and manage feelings.

DEVELOPMENTAL COMPETENCIES

Psychological & Emotional Development

Empathy

Positive self-regard

Sense of autonomy

Self-regulation skills

Positive coping skills

Conflict resolution skills

Optimism coupled with realism

Ability to comfort self and others

Recognition of right and wrong

Physical Development

Healthy Habits

Personal hygiene

Nutrition and exercise

Regular medical and dental care

Risk Management

Seat belts

Condoms

Bike helmets

Social Development

Sense of belonging to society

Connectedness with parents/cargivers, peers, and other adults

Attachment to pro-social institutions such as school and church

Ability to navigate in multiple cultural contexts

Commitment to civic engagement

Intellectual Development

Essential Life Skills:

Literacy

Budgeting and banking

Shopping and cooking

Transportation and Safety planning

Essential Vocational Skills:

Job applications and interviews

Time management

Knowledge of more than one culture

Critical thinking and reasoning

Decision-making and planning

SUPPORT THE WHOLE YOUTH

RESILIENCE PYRAMIDS:

FROM BIRTH TO YOUNG ADULTHOOD

RESILIENCE BUILDING BLOCKS

COMPETENCY
Mastering
developmental
tasks of adolescence
and the ability to plan
and organize for the future

SELF-REGULATION
Developing and maintaining the
ability to identify, express, and modulate
feelings such as frustration, anger, and fear

ATTACHMENT
The capacity to form and maintain a
healthy emotional bond with another person
as a source of mutual comfort, safety, and caring (12)

RESILIENCE IN REAL LIFE

YOUTH CAN
Be insightful,
Prioritize tasks,
Plan effectively,
Make good judgments, and
Organize thoughts and actions

YOUTH DEVELOPS
Empathy,
Impulse control,
Healthy boundaries, and
Conflict management skills

YOUTH PROVIDED WITH
Receptive, attuned cargiving from and adult (12)

PROVIDER SELF-CARE STRATEGIES FOR BURNOUT AND VICARIOUS TRAUMA

PEACE: *It does not mean to be in a place where there is no noise, trouble, or hard work. It means to be in the midst of these things and still be calm in your heart.*

–Author Unknown

BUILDING RESILIENCE: ABC'S OF SELF CARE (13)

A: Awareness of one's limits, resources, and emotions.

B: Balance among personal and professional activities.

C: Connection to one's inner self, to others, and to something "larger" (e.g. spiritual).

BUILDING RESILIENCE: HOW TO'S (14)

- Make connections and build good relationships.
- Avoid seeing crises as insurmountable problems.
- Accept that change is part of living.
- Move towards goals.
- Take decisive actions.
- Look for opportunities for self-discovery.
- Nurture a positive view of yourself.
- Keep things in perspective.
- Maintain a hopeful outlook.

STRESS/BURNOUT: DECREASE OVERUSE OF "DIRECTED ATTENTION"(15)

- "Directed attention" (watching TV) leads to more burnout, whereas "locomotion in nature" (e.g., walk in the park) and "fascination" is restorative and decreases burnout.

VICARIOUS TRAUMA: MINIMIZE UNNECESSARY EXPOSURE TO TRAUMATIC MATERIAL

- Reduce viewing of traumatic media, including violent movies and news about tragic events.

CONNECTION: THE SCIENCE OF POSITIVE PSYCHOLOGY

- Health and Happiness Ratio = 3:1
- 3 positive emotions are needed for each negative emotion (16)

Sources: 1) Joyce Dorado, (2013). Self-Care for Educators: Coping with Stress in School. UCSF Healthy Environment and Response to Trauma in Schools (HEARTS), Child and Adolescent Services, Dept. of Psychiatry, University of California, San Francisco. 2) Greater Good Science Center (2013). University of California Berkeley. http://greatergood.berkeley.edu/topic/happiness/definition#how_to_cultivate

RECOGNIZING AND RESPONDING TO TRAUMA TRIGGERS

Trauma triggers are reminders of past traumatic events. Past traumatic events may include:

- Physical, sexual, or emotional abuse
- Injuries or accidents
- Interpersonal, school, or community violence
- Natural disasters, war, or terrorism

Trauma triggers may include:

- Different types of physical contact
- Different sounds, smells, or places
- Dissagreements, conflicts, or certain topics of conversation
- Unpredictable situations or sudden changes

When triggered, you may react to "there and then" past traumatic events instead of "here and now" reality. Trauma triggers may cause you to:

- Yell or fight
- Get nervous, angry, or frustrated
- Shut down, get quiet, and want to be alone
- Drink, smoke, or eat to feel better

TIPS FOR RECOGNIZING TRAUMA TRIGGERS:

1. Notice your current mood, state of mind, and environment
2. Notice certain situations and places that remind you of past traumatic events
3. Notice when, where, and how you react to reminders of past traumatic events

TIPS FOR RESPONDING TO TRAUMA TRIGGERS:

Get Emotional: Talk to a trusted friend or caring adult about traumatic events, triggers, and reactions

Get Mindful: Stop what you are doing, pay attention to what's happening in your body, and breathe deeply

Get Physcial: Move your body- stretch, walk, run, or dance on a regular basis

Get Creative: Try writing in a journal, drawing, painting, freestyling, or singing

Get Spiritual: Meditate, go out in nature, or go to a religious place of worship

Get Community: Volunteer/participate in community projects such as murals, gardens, or mentoring

EXAMPLE: You smell cologne that reminds you of a time when you were raped. You are immediately triggered. You feel scared and begin to feel anxious.

RESPONSE 1: (You do NOT recognize your triggers). You decide to shake it off, call your friends, and get some drinks or go smoke to suppress your feelings. You hope the trigger never happens again. When you get home, you are left alone to deal with your fears and anxieties.

RESPONSE 2: (You do recognize your triggers). You are aware of your fears and anxieties and understand you have been triggered. You have already decided that when you are triggered you will stop, breathe deeply, and call your cousin to briefly talk about what happened. After expressing your emotions, you feel like it is an issue of the past and are able to continue with your day.

MINDFULNESS SKILLS

MINDFULNESS IS:

- Paying attention, here and now, with kindness and curiosity. (16)
- A mental state, characterized by focused awareness of one's thoughts, actions or motivations.
- A component of many therapeutic treatments for trauma.

BUILDING MINDFULNESS SKILLS CAN HELP YOUTH AND ADULTS:

1. Become more aware of negative judgments and thoughts.
2. Build more positive decision-making skills.
3. Become more focused on the moment.
4. Be less reactive to their environments.
5. Be utilized in group meetings or individual sessions with youth, or among adult providers.

MINDFULNESS "WHAT" SKILLS

Observe

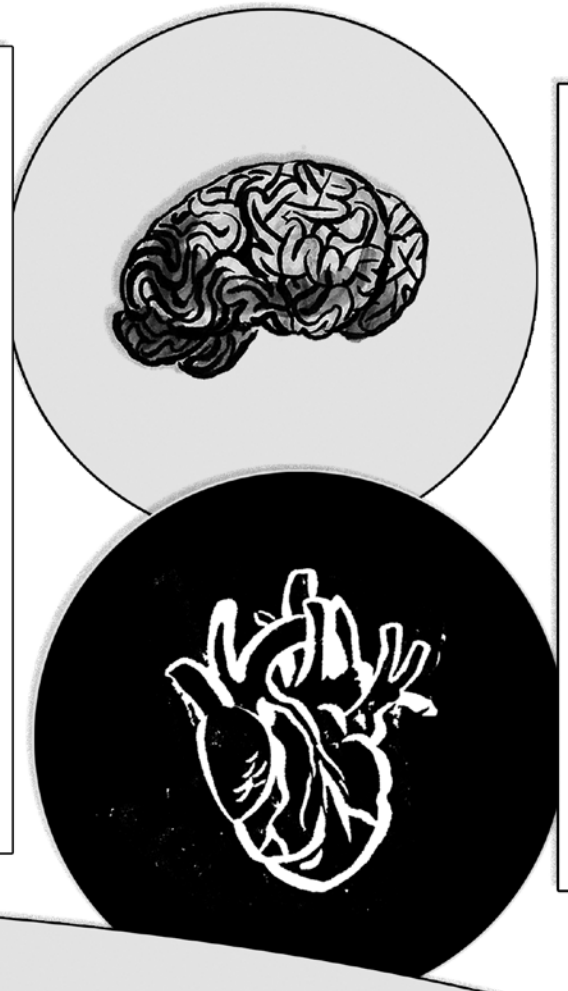
- Just notice: Use your 5 senses- sight, sound, taste, touch, smell
- Watch your thoughts and feelings come and go: Don't push them away or hold onto them

Describe

- Put words on the experience: "my stomach muscles are tightening"
- Name your feelings: "I'm so mad I could scream"
- Label your thoughts as thoughts, not facts: "Thinking you're dumb doesn't mean that you are dumb"
- Name thoughts, feelings, and sensations separately

Participate

- Become one with your experience
- Dive into what you do and get really into it without being self-conscious or fearful
- Practice, practice, practice, like learning how to ride a bike



MINDFULNESS "HOW" SKILLS

Don't judge

- See without evaluating
- Acknowledge without judgment
- Don't judge your judging

Stay focused

- Do ONE thing at a time
- Let go of distractions
- Dive into the current moment, the here and now
- Concentrate your mind

Do what works

- Focus on what's going to help
- Do what you need to do to achieve your goals
- Play by the rules
- Act as skillfully as you can
- Let go of feelings that hurt you and others

Source: SPARCS: Structured Psychotherapy for Adolescents Responding to Chronic Stress- Group Trauma Treatment Curriculum (V16).(16-18)

SLOW DOWN, ORIENT, AND SELF-CHECK (SOS): A TOOL FOR YOUTH/YOUNG ADULTS (19)

What is the situation? What is going on? _____

Practice steps 1, 2, & 3. Circle ratings for step 3.

STEP 1: SLOW DOWN

- Pause, take a time out, calm your body, relax.
- Take a deep breath- feel the air, listen to the sounds around you, notice your heartbeat.
- One thought at a time.

STEP 2: ORIENT YOURSELF

- Bring your mind and body back to the present time and place.
- Look around and notice where you are, who you're with, and what you're doing.
- Feel yourself (feet on the ground, sitting in a chair).

STEP 3: SELF CHECK

PERSONAL DISTRESS

Right Now I Feel...

Completely Calm	1	2	3	4	5	6	7	8	9	10	Most Distressed Ever

PERSONAL CONTROL

Right Now I Feel...

Completely in Control	1	2	3	4	5	6	7	8	9	10	Totally Out of Control

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CARE

SPECTRUM OF TRAUMA-INFORMED CARE: TERMINOLOGY

TRAUMA-SPECIFIC INTERVENTIONS (1)

- Practices developed to address trauma experienced by individuals, families, and communities.
- Shown to work with specific age groups, settings, and types of trauma.
- Most often used by practitioners trained in the specific intervention.

TRAUMA-SPECIFIC SERVICES (2)

- Programs that address trauma with a continuum of interventions from screening to treatment to recovery supports.
- Recognize that recovery occurs within a context of relationships.
- Characterized by belief in persuasion and trust rather than coercion, ideas rather than force, and mutuality rather than control.

TRAUMA-INFORMED CARE/APPROACHES (3)

- A program, organization, or system that realizes the widespread impact of trauma and understands potential paths for healing.
- Recognizes signs and symptoms of trauma in providers, clients, and others involved with the system.
- Responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings.
- **Trauma-informed approaches ask: "What happened to you?" NOT "What's wrong with you?"**

THREE R'S OF TRAUMA-INFORMED APPROACHES TO CARE

WHAT IS A TRAUMA-INFORMED APPROACH? (2,3)

- How a program, agency, organization or community thinks about and responds to those who have experienced or may be at risk for experiencing trauma- includes a change in organizational culture.
- All components of the organization incorporate a deep understanding of the prevalence and impact of trauma, the role that trauma plays, and the complex and varied paths in which people recover and heal.
- Designed to avoid re-traumatizing those who seek assistance, to focus on safety first, commitment to do no harm, and facilitates participation and meaningful involvement of consumers, families, and trauma survivors in the planning of services and programs.
- Requires closely knit collaborative relationships with other public sector service systems.

THREE KEY ELEMENTS

1. *Realizing* the prevalence of trauma.
2. *Recognizing* how trauma affects all individuals involved with programs, organizations, or systems, including the workforce.
3. *Responding* by putting knowledge into practice.

REALIZING

- All people at all levels of an organization or system have a basic realization about trauma and understand how trauma affects individuals, groups, organizations, and communities.
- There is an understanding that trauma plays a role in mental and substance use disorders and should be systematically addressed in treatment and recovery settings.
- There is a realization that trauma is not confined to the behavioral health service sector- trauma is integral to all other systems including child welfare, criminal justice, primary health care, and education, and is often a barrier to effective outcomes across systems of care.

RECOGNIZING

- People in the organization or system are able to recognize the signs of trauma.
- Signs may be gender, age, or setting-specific and may be experienced by those seeking service and those providing services.
- The organization assumes that everyone is at risk of experiencing a traumatic event at some point in life and might benefit from a trauma-informed approach, including trauma screening and assessment.

RESPONDING

- Programs, organizations, or systems respond by applying the principles of a trauma -informed approach to all areas of functioning.
- People in every part of the organization, from the front desk to the executive, have changed their language, behaviors and policies to take into consideration the experiences of trauma among children and adult users of services and among service providers.
- Organizations have a meaningful definition of trauma; have a culture based on beliefs about resilience, recovery and healing; and accept key values and principles that guide the way the organization is designed, operated, and provides services to meet the unique needs of those impacted by trauma.

Source: National Association of State Mental Health Program Directors (2012, September). Changing Communities, Changing Lives. Report prepared for the Substance Abuse and Mental Health Services Administration's National Center for Trauma-Informed Care. Alexandria, VA: (Joan Gillece, Project Director; Andrea Blanch, Author).

KEY PRINCIPLES OF TRAUMA-INFORMED APPROACHES TO CARE

A trauma-informed approach reflects the adoption of underlying values or principles rather than a specific set of procedures. These values or principles are generalizable across all settings, although language and application may be setting or sector-specific.

1. ***SAFETY:*** Throughout the organization, providers and people served feel physically and psychologically safe; including physical settings and interpersonal interactions.

2. ***TRUSTWORTHINESS AND TRANSPARENCY:*** Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among providers, clients, and family members of those served.

3. ***COLLABORATION AND MUTUALITY:*** There is true partnering and leveling of power differences between providers and clients and among organizational staff from direct care to administrators; there is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.

4. ***EMPOWERMENT:*** Throughout the organization and among clients served, individuals' strengths are recognized and validated and new skills are developed as necessary.

5. ***VOICE AND CHOICE:*** The organization aims to strengthen client and family members' experience of choice, and recognizes that every person's experience is unique and requires an individualized approach.

6. ***PEER SUPPORT AND MUTUAL SELF-HELP:*** Are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.

7. ***RESILIENCE AND STRENGTHS BASED:*** A belief in resilience and the ability of individuals, organizations, and communities to heal and promote recovery from trauma; builds on what clients, providers, and communities have to offer rather than responding to their perceived deficits.

8. ***INCLUSIVENESS AND SHARED PURPOSE:*** The organization recognizes that everyone has a role to play in a trauma-informed approach; one does not have to be a therapist to be therapeutic.

9. ***CULTURAL, HISTORICAL, AND GENDER ISSUES:*** Are addressed; the organization actively moves past cultural stereotypes and biases, offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.

10. ***CHANGE PROCESS:*** Is conscious, intentional and ongoing; the organization strives to become a learning community, constantly responding to new knowledge and developments.

Source: Substance Abuse and Mental Health Services Administration (SAMHSA). 2012. Trauma Definition Working Draft. http://www.samhsa.gov/traumajustice/traumadefinition/index.aspx

GUIDELINES FOR IMPLEMENTATION OF TRAUMA-INFORMED APPROACHES TO CARE

Guidelines can provide a roadmap to help individuals and agencies get started in the process of implementing a trauma-informed approach. In a trauma-informed approach, change permeates all levels of an organization or system, and all aspects of organizational culture are in alignment. While different organizations have varying responsibilities and influence, the following organizational domains are identified as potentially relevant across a variety of settings.

1. ***GOVERNANCE AND LEADERSHIP:*** Leadership and governance bodies support and invest in implementing and sustaining a trauma-informed approach. There is an identified point of responsibility within the organization to lead and oversee this work.

2. ***POLICY:*** There is a written policy establishing a trauma-informed approach as an important part of the organizational mission.

3. ***INVOLVEMENT OF TRAUMA SURVIVORS, CONSUMERS, AND FAMILY MEMBERS:*** These groups have significant involvement, voice, and meaningful choice at all levels and in all areas of organizational functioning, (e.g., program design, implementation, service delivery, quality assurance, access to peer support, workforce development, and evaluation).

4. ***CROSS SECTOR COLLABORATION:*** There is collaboration between adult and children/youth services, prevention and treatment, health and human service sectors, education, legal, child welfare, and criminal justice sectors and systems.

5. ***ORGANIZATIONAL PROTOCOLS:*** Organizational procedures reflect trauma-informed principles, including collaborations with other agencies.

6. ***INTERVENTIONS:*** All interventions, including screening and assessment, are based on the best available empirical evidence, are culturally appropriate, and reflect principles of a trauma-informed approach. A trusted and effective referral system is in place, and trauma-specific interventions are acceptable, effective, and available for individuals, youth, and families seeking services.

7. ***TRAINING AND WORKFORCE DEVELOPMENT:*** Training on trauma and how to respond is available for all staff. A human resource system incorporates trauma-informed principles in hiring, supervision, and staff evaluation. Procedures are in place to support staff with trauma histories.

8. ***CONSULTATION AND SUPERVISION:*** All levels of staff receive regular and ongoing consultation and supervision around issues of trauma, vicarious trauma, and burnout faced in the work place, including interactions between staff and clients, and among staff themselves.

9. ***PHYSICAL ENVIRONMENT:*** Investments are made to ensure the physical environment promotes a sense of safety for clients and staff.

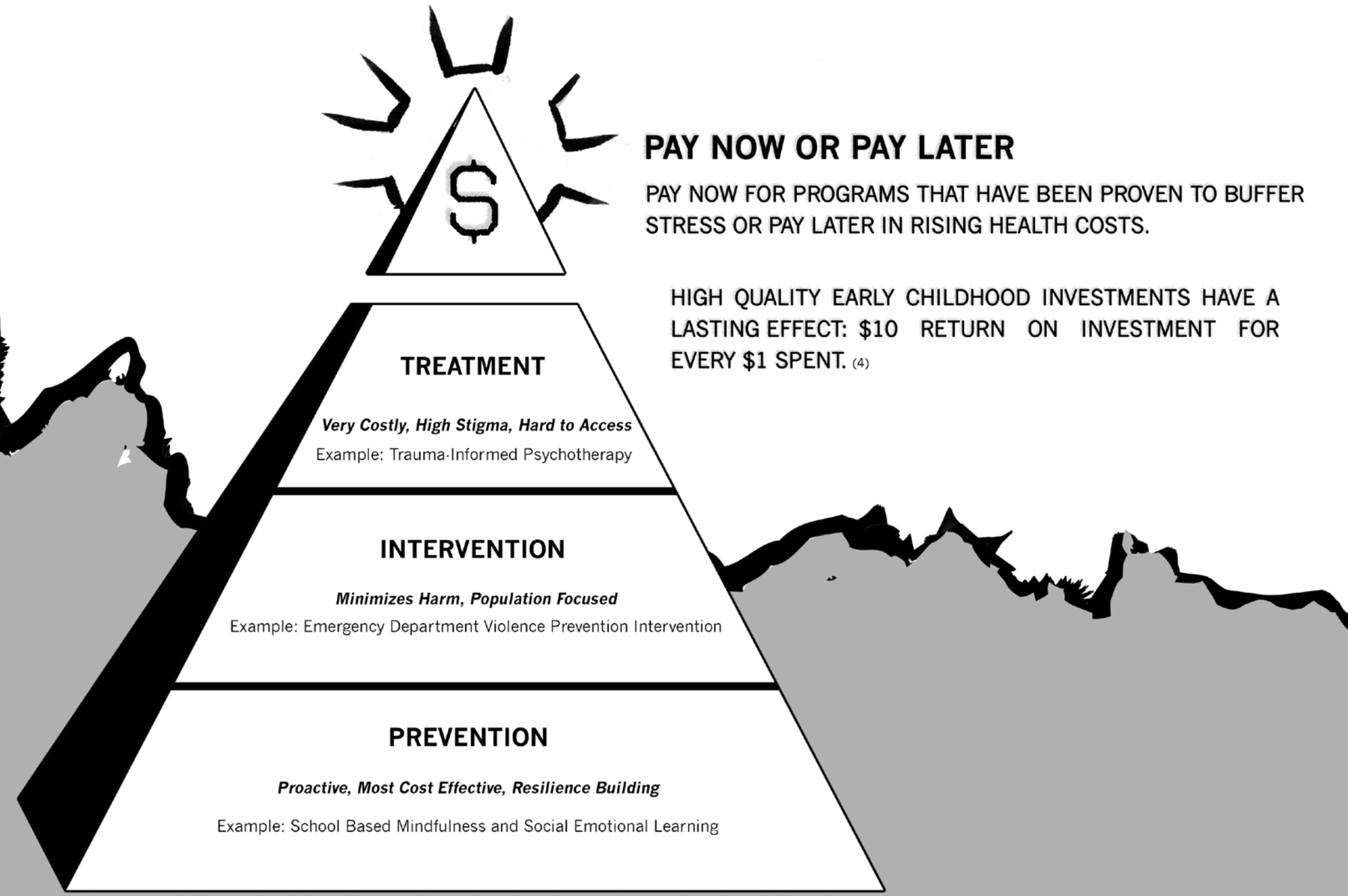
10. ***QUALITY ASSURANCE:*** There is ongoing assessment, tracking, and monitoring of trauma-informed principles.

11. ***FINANCING:*** Financial structures are designed to support a trauma-informed approach including initial staff training, ongoing consultation, supervision, and support for all staff, appropriate facilities, and evidence based trauma-specific services.

12. ***EVALUATION:*** Measures used to evaluate service or program effectiveness reflect an understanding of trauma.

Source: Substance Abuse and Mental Health Services Administration (SAMHSA). 2012. Trauma Definition Working Draft. http://www.samhsa.gov/traumajustice/traumadefinition/index.aspx

TRAUMA-INFORMED PREVENTION, INTERVENTION, AND TREATMENT PYRAMID



PAY NOW OR PAY LATER

PAY NOW FOR PROGRAMS THAT HAVE BEEN PROVEN TO BUFFER STRESS OR PAY LATER IN RISING HEALTH COSTS.

HIGH QUALITY EARLY CHILDHOOD INVESTMENTS HAVE A LASTING EFFECT: $10 RETURN ON INVESTMENT FOR EVERY $1 SPENT. (4)

CULTURALLY SENSITIVE APPROACHES TO TRAUMA

APPROACHES THAT ARE NOT TRAUMA-INFORMED ASK: "WHAT'S WRONG WITH YOU."	TRAUMA-INFORMED APPROACHES ASK: "WHAT HAPPENED TO YOU."
WHAT "HELP" LOOKS LIKE (NOT TRAUMA-INFORMED)	**WHAT "HELP" LOOKS LIKE (TRAUMA-INFORMED)**
• The "helper" decides what "help" looks like.	→ • A sense of trust and safety is mutually defined, created, and sustained in all relationships.
• Focused on "needs" as defined by helper.	→ • Collaboration and shared decision-making exists.
• Relationships are based solely on problem-solving and resource coordination, not creating meaningful connections.	→ • Crisis becomes opportunity for growth and connection.
• Safety is defined only as risk management.	→ • Authentic relationships are emphasized in a context of wellness.
• Common experience is assumed and defined by setting: i.e. in clinical setting experience is based only on "illness" and coping with "illness."	→ • It is recognized that people rarely have the same experience or make the same meaning out of similar events.

COMMON CULTURAL MISTAKES ABOUT TRAUMA	MORE CULTURALLY SENSITIVE APPROACHES TO TRAUMA (5)
• Assuming everyone who has experienced violence needs professional help.	→ • Assuming people are resilient and giving them many opportunities to tell you if they need help.
• Focusing on the most extreme instances of violence as the most damaging.	→ • Allowing individuals to define what aspects of their experiences have been most traumatic and recognizing that this may change over time.
• Assuming that violence is unusual, an aberration, and generally perpetrated by individuals.	→ • Recognizing that violence is perpetrated by groups and institutions, not only individuals, and may be so common that people become desensitized to it.
• Relying only on DSM diagnoses or lists of trauma "symptoms."	→ • Recognizing that political and social oppression may affect priorities and values; allowing individuals to define the meaning of their experiences.
• Applying norms and standards of behavior without considering political and social context.	→ • Recognizing that trauma responses are varied and that different cultures express grief and loss and understand trauma differently; learning how different people and cultures expresses distress.
• Assuming that one person's story represents the "typical" story for a group of people.	→ • Recognizing that one person's story is just one person's story.
• Inadvertently highlighting the stories of people that fit cultural stereotypes.	→ • Providing opportunities for many people to share their stories, noticing what is unique, and making sure many points of view are represented.
• Assuming that if people speak English, you don't have to worry about an interpreter or translated documents.	→ • Recognizing that some topics are very difficult to talk about in anything other than your first language; knowing and acting within the law about provision of language assistance services.
• Assuming that people always (or never) want to tell their stories and that if people want help they will ask for it.	→ • Being aware that self-disclosure and help-seeking vary widely across cultures and may be dependent upon whether an individual feels safe; learning different cultural norms and expectations.

Source: Engaging Women in Trauma-Informed Peer Support: A Guidebook. Blanch, A., Filson, B., and Penny, D., 2012. http://www.nasmhpd.org/publications/engagingWomen.aspx

RESTORATIVE PRACTICES FOR TRAUMA-INFORMED CARE

RESTORATIVE PRACTICES

Foundation: People are happier, more cooperative and productive, and more likely to make positive changes when those in positions of authority do things with them, rather than to them or for them.
Includes: "Restorative justice" (criminal justice), "empowerment" (social work), "trauma-informed consequences," (behavioral health), "positive discipline" (education), and "horizontal management" (organizational leadership).
Examples: In schools, the use of restorative practices has demonstrated reliable reduction of misbehavior, bullying, violence and crime among students and improvements in overall learning climates.(6)In juvenile justice, the use of restorative practices has demonstrated significant reductions in offending rates and improvements in youth attitudes.(6)

PUNISHMENT VS. CONSEQUENCES

Punishment: Used by specific authorities to enforce obedience. Usually used to assert power and control and often leaves youth feeling helpless, powerless, and shamed.
Consequences: Intentionally designed to teach, change, or shape behavior. Logical consequences are clearly connected to behavior, given with empathy and a respectful tone, and are reasonable to the behavior.

CONSISTENCY AND INDIVIDUALIZED RESPONSES

Consistency: Rules and consequences apply to everyone, understanding that predictability and routines can help a youth feel safe.
Individualized Responses: Consequences are consistent with youth's needs and level of functioning, while also holding youth accountable for their actions. Some youth are more highly impacted by past traumatic experiences and may need tailored consequences.

ADOLESCENT DEVELOPMENT AND TRAUMA-INFORMED CONSEQUENCES

- The adolescent brain is acutely sensitive to positive reward and relatively insensitive to negative consequences.(7)
- Disrupting service delivery or learning (i.e. exiting youth from a program/site or restricting participation) may lead to more negative outcomes than positive.
- Some youth will repeatedly test limits and challenge providers with their behaviors until they build trust and feel connected.
- If providers have to ask youth to leave or restrict access due to safety concerns, maintaining contact with the youth can "open the door" to important learning opportunities and engagement.

CHARACTERISTICS OF TRAUMA INFORMED CONSEQUENCES

- Take into account trauma triggers and past traumatic experiences.
- Attempt to retain youth in services/learning, in spite of problematic behavior.
- Consider the function of problematic behavior and help youth develop more effective strategies for getting needs met.
- Shape youth's behavior by assisting them to recognize the impact of their actions on themselves and their community.
- Build youth's capacity to manage strong emotions and increase confidence in what they are able to accomplish.
- Invest great energy, creativity, and resources upfront in order to support long-term success in helping youth succeed.
- Take the long view and understand that behavior change is slow and incremental.

CHALLENGES OF IMPLEMENTING TRAUMA-INFORMED CONSEQUENCES

- May require a paradigm shift in the way providers understand and respond to challenging, negative, and disruptive behavior.
- Providers must balance what is best for individual youth with needs of other youth and the agency as a whole.
- Best implemented in a calm and thoughtful manner, with time for planning and processing between youth and providers, and among providers and administrators.
- Provider safety and wellness must be attended to in order for providers to feel well equipped to be attuned and responsive to youth.
- Providers must receive adequate supervision and ongoing support for learning and implementing trauma-informed consequences.

Sources: 1) Wachtel, T. (2012). Defining Restorative. International Institute for Restorative Practices. www.iirp.edu. 2) Schneir, A., Ballin, D., Carmichael, H., Stefanidis, N., Phillips, L., Hendrickson, C., and de Gyarfas, L. 2009. The Community Trauma Treatment Center for Runaway and Homeless Youth. An Initiative of the Hollywood Homeless Youth Partnership. SAMHSA Grant # SM57247. http://hhyp.org/download-material-2/

TRAUMA-INFORMED CONSEQUENCES IN PRACTICE (PAGE 1 OF 3)

Well-intentioned providers assisting youth with trauma histories and behavioral challenges may unknowingly mirror aspects of traumatic relationships:

Characteristics of Traumatic Relationships

- Betrayal occurs at the hands of a trusted caregiver or supporter.
- Hierarchical boundaries are violated and then re-imposed at the whim of the abuser.
- Secret knowledge, secret information, and secret relationships are encouraged and maintained.
- The voice of the victim is unheard, denied, or invalidated.
- The victim feels powerless to alter or leave the relationship.
- Reality is reconstructed to represent the values and beliefs of the abuser.
- Events are reinterpreted and renamed to protect the guilty.

How Helping Relationships Can Re-traumatize Youth

- Youth feel betrayed by the organization, program, or provider.
- Youth-provider relationships are inconsistent, unclear, or confusing.
- Provider-agency relationships allow for and maintain secrets.
- Youth feel there is no opportunity to be heard, and their perspectives are not taken into account.
- Youth feel powerless to alter or leave the relationship or agency.
- Reality is reconstructed to match the needs and values of the provider or agency, not the youth.

As providers respond to challenging behaviors with trauma-informed consequences, it may be useful to explore the following questions and answers:

1. What is the purpose of enforcing rules? Is it to discipline/teach youth how to manage emotions, or to enforce the rules for the "rule's sake?"
2. Is a youth intentionally pushing my buttons? Why would the youth want this type of attention from me? Does the youth prefer negative attention to no attention at all?
3. How much of my response is because I feel personally hurt, offended, disrespected, helpless and frightened, or need to prove that I am in control?
4. What assumptions am I making about this youth's behavior? Could there be another explanation?
5. What options do I have to respond to this behavior? How does the youth expect me to respond?
6. Which option most closely fits my intent to maintain safety while building the youth's capacity to manage intense emotions and learn more effective behavior? Which option is least disruptive to service/learning delivery?

Why does it seem like some youth are asking to be discharged from services by repeatedly breaking the rules even when they know the consequences?

Many youth bring multiple experiences of rejection and abandonment by family and other caregivers. Due to past experiences, there is an expectation that providers will also reject them and, in turn, abandon them. In order to protect themselves, consciously or not, many youth act out to speed up the rejection that they are convinced is coming anyway.

If we don't exit/punish youth when they break the rules, aren't we enabling them?
No. When a youth that is highly impacted by past trauma is exited, what is the lesson? Although providers may believe youth are learning they can't write on walls or disrespect providers, mostly providers are just confirming a youth's belief that they are unlovable and undeserving of attention and support. It is not suggested that agencies and providers ignore inappropriate behavior. Instead, it is recommended that providers work with youth to identify problematic behavior, put it in the context of trauma, and help youth find different ways to express anger, frustration, or sadness. The goal is for youth to know that providers can see far beyond the problem behavior, and see the youth's capabilities and potential to succeed.

Source: Stefanidis, N., Schneir, A., Ballin, D., Carmichael, H., Gore, P., de Gyarfas, L., Hendrickson, C., Hubbard, E., McGaffey, J., Phillips, L., Rodriguez, M., and Schwartz, J. (2010). Trauma-Informed Consequences for Homeless Youth. The Community Trauma Treatment Center for Runaway and Homeless Youth. SAMHSA Grant #SM57247. ©Hollywood Homeless Youth Partnership. http://hhyp.org/download-material-2/

TRAUMA-INFORMED CONSEQUENCES IN PRACTICE (PAGE 2 OF 3)

INCIDENT # 1: Youth is verbally aggressive towards a provider.

Punishment

Provider Interpretation: Youth is being disrespectful. Youth doesn't appreciate the services/learning offered. A firm example needs to be set condoning this type of verbal abuse.

Reaction: Provider threatens to exit youth if behavior continues.

Trauma-Informed Consequences

Provider Reflection and Interpretation: What is going on in the environment that is setting the youth off? Youth needs to know it's inappropriate to verbally abuse providers and at the same time get help to develop more constructive self-regulation skills.

Response: Youth is asked to cool off in a safe place. Provider processes the experience with the youth when appropriate (i.e. after the youth is no longer visibly agitated). Provider shares with youth their observation regarding the interaction and asks for feedback. Provider and youth explore alternative/pro-social ways of communicating feelings.

INCIDENT # 2: Youth comes to agency/site but doesn't do anything, just sits and dozes.

Punishment

Provider Interpretation: The youth is lazy, is taking advantage of services/learning, and should be doing something productive. Providers help youth, not just let them sit around and do nothing.

Reaction: Providers don't invest time in the youth.

Trauma-Informed Consequences

Provider Reflection and Interpretation: The youth is very tired. Services/learning were made available to the youth. What could be interfering with the youth's ability to participate/focus? Lots of youth are worried about failing so they don't even want to try. How can the youth be engaged?

Response: Provider approaches the youth and asks if anything is needed. Provider tries to engage youth in pro-social activity (i.e. game, group) to try and engage further. Even if the youth is generally unresponsive, the provider gently continues to try and engage periodically and spends as much time with the youth as tolerated by the youth.

INCIDENT # 3: Youth has a crush on a provider and follows them around.

Punishment

Provider Interpretation: This is very awkward. I don't want to hurt the youth's feelings but I don't want to give them the wrong idea. It is probably better if the youth works with someone else.

Reaction: Youth is given a new provider.

Trauma-Informed Consequences

Provider Reflection and Interpretation: This young person is trying to connect with me. I might be one of few people who sincerely tried to help this youth. This is very awkward but with some supervision and support, I think I can help.

Response: Provider gets supervision and support in talking to the youth about the crush and working to reinforce appropriate boundaries and expectations.

Source: Stefanidis, N., Schneir, A., Ballin, D., Carmichael, H., Gore, P., de Gyarfas, L., Hendrickson, C., Hubbard, E., McGaffey, J., Phillips, L., Rodriguez, M., and Schwartz, J. (2010). Trauma-Informed Consequences for Homeless Youth. The Community Trauma Treatment Center for Runaway and Homeless Youth. SAMHSA Grant #SM57247. ©Hollywood Homeless Youth Partnership. http://hhyp.org/download-material-2/

TRAUMA-INFORMED CONSEQUENCES IN PRACTICE (PAGE 3 OF 3)

INCIDENT # 4: Youth acts out and storms out of a group/class.

Punishment

Staff Interpretation: This young person is disrespecting the group and disrespecting me. I can't create a cohesive group when the youth feels free to leave at will. It's not fair to the other youth participants/learners.

Reaction: Youth receives a warning to be exited from the group/class if it happens again.

Trauma-Informed Consequences

Provider Reflection and Interpretation: Did something in the group/class trigger the youth or bring up uncomfortable feelings or memories? What else could I do to help the youth feel safe?

Response: Provider checks in to find out if the youth is ready to rejoin the group/class. If not, the provider talks to the youth after the group/class to find out what happened. The provider lets the youth know where they can go during a group/class, when feeling upset or anxious, to sit quietly or talk with a trusted adult (i.e. safe space- counselor, wellness center, etc). The provider invites the youth to rejoin the group/class when ready.

INCIDENT # 5: Youth enters agency/site clearly drunk or high.

Punishment

Provider Interpretation: The youth knows they are not allowed to come to the agency/site under the influence. This is totally disruptive to other youth and providers. Youth needs to learn that this is just not allowed.

Reaction: Youth is exited and referred to detox/rehab.

Trauma-Informed Consequences

Provider Reflection and Interpretation: This is disruptive to other youth and providers. However, if I send the youth back outside, they will be vulnerable to being victimized or offending. We need to find a safe place for the youth to sober up. Youth needs further assessment regarding substance use.

Response: Youth is asked to move to secure place within agency/site to sober up and be safe. When youth is more coherent, a provider discusses the circumstances of youth's drug/alcohol use. The youth is reminded about the provider's concern for the youth's safety and the agency/site policies about using. The youth is encouraged to speak to a substance abuse counselor.

Source: Stefanidis, N., Schneir, A., Ballin, D., Carmichael, H., Gore, P., de Gyarfas, L., Hendrickson, C., Hubbard, E., McGaffey, J., Phillips, L., Rodriguez, M., and Schwartz, J. (2010). Trauma-Informed Consequences for Homeless Youth. The Community Trauma Treatment Center for Runaway and Homeless Youth. SAMHSA Grant #SM57247. ©Hollywood Homeless Youth Partnership. http://hhyp.org/download-material-2/

TRANSFORMING TRAUMA THROUGH SOCIAL ACTION

SOCIAL ACTION: A TOOL FOR HEALING FROM TRAUMA

- Trauma often leaves survivors feeling voiceless, hopeless, and powerless.
- Taking social action, individually or as part of a group, can be a positive act of healing for trauma survivors, especially those in positions of lesser cultural power, including youth, women, and people of color, and can help to reclaim power in the world.
- Social action includes working to change harmful policies and practices and overcome injustice.
- Social action requires many different skills, which provides opportunities for all group members to utilize their strengths and make significant contributions.
- The process of healing from trauma often includes: 1) An increased sense of awareness and rage about the traumatic events experienced; and 2) Outrage at the sight of others harmed or treated unjustly.
- If anger and rage is left unexamined and unchecked, it can be hurtful to the self and others.
- If anger and rage is recognized and transformed to help the self and others, it can be a powerful force for positive healing and social change.

A GOOD PLACE TO START

In order to break down a social issue and create a strong position on which to enact change, individuals and groups can start by answering the following questions:

- What is it we want to change?
- What outcomes or solutions will satisfy us?
- What are we willing/not willing to trade, compromise, or let go of?
- What information already exists on the issue and what struggles are currently being fought for the issue?
- Is a rule, policy, or law being violated?
- What additional information/resources are needed and how will the group get them?
- Who has the power to change the situation/fix the problem, and how can the group engage them in the struggle?
- What are possible barriers and solutions to reaching an outcome that facilitates healing and social change for those involved?
- When there is conflict, is there a point of shared interest on which there is some agreement?

NEXT STEPS

- Develop a clear and concise understanding of the problem and desired solution to the problem in about five spoken sentences and no more than one written page; this is the position statement.
- When presenting the position statement, focus on facts not feelings for greatest impact on the decision-maker.
- Decide who to approach and how to approach them.
- Try starting with the lowest pressure technique and apply only as much as necessary to succeed.
- The activities below are arranged in order of increasing pressure, from lowest to highest:
    - o Meet with management or policy makers.
    - o Meet with the responsible government officials.
    - o Develop letter-writing, fax, phone, e-mail, and social network campaigns.
    - o Develop and distribute position papers and fact sheets throughout the community.
    - o Join relevant committees and task forces.
    - o Testify at public hearings.
    - o Launch media campaigns.
    - o Organize rallies and demonstrations.
    - o File lawsuits.

ADDITIONAL RECOMMENDED ACTIVITIES

- Create healing circles and opportunities to connect and bond in peer groups and across multiple generations.
- Organize candle light vigils to honor those lost/injured and to mourn as a community.
- Design public murals and artwork that represents community strength and power.

Source: Engaging Women in Trauma-Informed Peer Support: A Guidebook. Blanch, A., Filson, B., and Penny, D. (2012). http://www.nasmhpd.org/publications/engagingWomen.aspx

MANY MEDICINES:

TRUAMA-INFORMED EVIDENCE-BASED BEST PRACTICES AND PROMISING APPROACHES (PAGE 1 OF 6)

For extended and updated listings of programs nationwide, please visit:
National Child Traumatic Stress Network (NCTSN): http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices
Substance Abuse Mental Health Services Administration (SAMHSA): http://www.nrepp.samhsa.gov/

EMERGENCY DEPARTMENT VIOLENCE PREVENTION INTERVENTION

Designed to: Reduce injury recidivism and criminal recidivism by working directly with survivors of violent injury and connecting at teachable moments in the hospital setting.

Components:

- May include intensive case management, crisis response, mental health services for youth/young adults and families, along with access to after school, vocational, life skills, and tattoo removal programs.

Resources:

1. National Network of Hospital Based Violence Intervention Programs
   www.nnhvip.org
2. Youth Alive
   www.youthalive.org/caught-in-the-crossfire
3. Wrap-Around Project
   www.violenceprevention.surgery.ucsf.edu

EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

Designed to: 1) Overwrite original memory of the trauma with more adaptive beliefs, emotions, and somatic responses, and 2) Reduce trauma-related stress, anxiety, and depression symptoms.

Components:

- 1-3 or more 60-90 minute sessions depending on complexity of trauma.
- Target trauma triggers and related psychological distress are reviewed and processed with a focus on accessing positive images and beliefs.
- Repetitive 30-second dual-attention exercises, typically side-to-side eye movements guided by therapist's finger, are repeated until client reports no distress.

Resources:

EMDR Training Institute: http://www.emdr.com/index.php

PHARMACOTHERAPY

Designed to: Reduce specific post traumatic stress related symptoms including nightmares, difficulty sleeping, and anxiety.

Components:

- Medication treatment to be taken as prescribed by doctor.

Resources:

National Child Traumatic Stress Network
http://www.nctsnet.org/sites/default/files/assets/pdfs/effective_treatments_youth_trauma.pdf

TRAUMA FOCUSED COGNITIVE BEHAVIORAL THERAPY (TF-CBT)

Designed to: Reduce levels of post traumatic stress symptoms including anxiety, depression, and dissociation.

Components:

- 60-90 minute sessions once a week for 12-16 weeks, based on PRACTICE skills.
- P: Psycho-education about childhood trauma and PTSD for youth and parent/caregiver.
- P: Parenting management skills for parent/caregiver.
- R: Relaxation skills individualized to youth and parent/caregiver.
- A: Affective modulation skills adapted to the youth, family and culture.
- C: Cognitive coping: connecting thoughts, feelings, and behaviors related to trauma.
- T: Trauma narrative: assisting youth in sharing verbal, written, or artistic narrative about the trauma and related experiences, and cognitive and affective processing of the trauma experiences.
- I: In vivo exposure and mastery of trauma reminders if appropriate.
- C: Conjoint parent-youth sessions to practice skills and enhance trauma-related discussions.
- E: Enhancing future personal safety and enhancing optimal developmental trajectory through providing safety and social skills training as needed.

Resources:

Web Based Learning Course for TF-CBT
http://tfcbt.musc.edu

MANY MEDICINES:

TRUAMA-INFORMED EVIDENCE-BASED BEST PRACTICES AND PROMISING APPROACHES (PAGE 2 OF 6)

ATTACHMENT, SELF-REGULATION, AND COMPETENCY (ARC)

Designed to: : 1) Reduce posttraumatic stress symptoms, anxiety, and depression, 2) Increase adaptive and social skills among youth, and 3) Reduce distress among parents/caregivers, and 3) Parents/caregivers view their children's behaviors as less dysfunctional.

Components:

- Flexible framework, rather than a protocolized intervention for working with youth and families who have experienced multiple and/or prolonged traumatic stress.
- Identifies three core domains frequently impacted among traumatized youth, and relevant to future resiliency: attachment, self-regulation, and competency.
- Identifies ten building blocks of trauma-informed treatment and services within the core domains.
- Attachment: 1) caregiver affect management, 2) attunement, 3) consistent response, 4) routines and rituals.
- Self regulation: 5) affect identification, 6) affect modulation, 7) affect expression.
- Competency: 8) developmental tasks, 9) executive functioning, 10) self development.

Resources:

Trauma Center at Justice Resource Institute
http://www.traumacenter.org/research/ascot.php

STRUCTURED PSYCHOTHERAPY FOR ADOLESCENTS RESPONDING TO CHRONIC STRESS (SPARCS)

Designed to: Address the needs of chronically traumatized adolescents who may still be living with ongoing stress and experiencing problems in several areas of functioning.

Components:

- 16-session group intervention.
- Areas include: difficulties with affect regulation and impulsivity, self-perception, relationships, somatization, dissociation, numbing and avoidance, struggles with purpose, meaning, and worldviews.
- Group members learn and practice each of the core SPARCS skills including: mindfulness practice, relationship building/communication skills, distress tolerance, problem-solving, and meaning making.
- Treatment also includes psychoeducation regarding stress, trauma, and triggers.

Resources:

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
http://sparcstraining.com/

INTEGRATIVE TREATMENT OF COMPLEX TRAUMA

Designed to: 1) Decrease depression, anxiety, anger, posttraumatic stress, dissociation, internalizing symptoms, externalizing symptoms, and sexual concerns, 2) Increase affect regulation capacities, enhanced self-esteem, and a greater sense of self-efficacy.

Components:

- 16-36 sessions.
- Interventions are adapted to youth's specific symptoms, culture, and age, and include relationship-building, psychoeducation, affect regulation training, trigger identification, cognitive processing, titrated emotional processing, mindfulness training, collateral treatments with parents and families, group therapy, and system-level advocacy.
- Specific approaches for complex trauma treatment include aspects of the Self Trauma model (Briere, 2002; Briere & Scott, 2006), Trauma Focused Cognitive Behavioral Therapy (Cohen et al., 2004), and traumatic grief therapy (Saltzman et al., 2003).

Resources:

Integrative Treatment of Complex Trauma for Adolescents (ITCT-A): A Guide for the Treatment of Multiply-Traumatized Youth
www.johnbriere.com

TRAUMA AFFECT REGULATION: GUIDE FOR EDUCATION AND THERAPY (TARGET)

Designed to: Prevent and reduce PTSD symptoms, including rage, traumatic grief, survivor guilt, shame, interpersonal rejection, and existential/spiritual alienation.

Components:

- 10 sessions, based on FREEDOM skills.
- F: Self-regulation via Focusing (SOS: Slow down, Orient, Self-Check)
- R: Processing current traumatic stress reactions via Recognizing current triggers
- EE: Emotions, and cognitive Evaluations
- D: Strength-based reintegration by Defining core goals
- O: Identifying currently effective responses (Options)
- M: Affirming core values by Making positive contributions

Resources:

Trauma Affect Regulation: Guide for Education and Therapy
http://www.ptsdfreedom.org/index.html
Advanced Trauma Solutions
http://www.advancedtrauma.com/index.html

MANY MEDICINES:

TRUAMA-INFORMED EVIDENCE-BASED BEST PRACTICES AND PROMISING APPROACHES (PAGE 3 OF 6)

SEEKING SAFETY

Designed to: Reduce substance abuse and post traumatic stress symptoms.

Components:

- Safety: Helping clients attain safety in their relationships, thinking, behavior, and emotions.
- Integrated treatment: Working on both PTSD and substance abuse at the same time.
- A focus on ideals to counteract the loss of ideals in both PTSD and substance abuse.
- Four content areas: cognitive, behavioral, interpersonal, case management.
- Attention to clinician processes: Helping clinicians work on countertransference, self-care, and other issues.

Resources:

Seeking Safety: A Model for Trauma and/or Substance Abuse

www.seekingsafety.org

COGNITIVE BEHAVIORAL INTERVENTION FOR TRAUMA IN SCHOOLS (CBITS)

Designed to: 1) Reduce symptoms of post-traumatic stress, depression, and behavioral problems, 2) Improve functioning, grades, attendance, peer and parent support, and coping skills.

Components:

- Includes 10 group sessions; 1-3 individual sessions; 2 parent psychoeducational sessions; 1 teacher educational session
- Cognitive-behavioral techniques include psychoeducation, relaxation, social problem solving, cognitive restructuring/how to challenge upsetting thoughts, and exposure/processing traumatic memories.

Resources:

Cognitive Behavioral Intervention for Trauma in Schools

http://cbitsprogram.org

SOMATIC EXPERIENCING (SE)

Designed to: 1) Complete the initiated survival responses unable to be completed at initial time of trauma, and discharge the neurological memory stored in the peripheral nervous system, 2) Restore self-regulation, resilience, equilibrium, and a sense of wholeness.

Components:

- Nine Step Method for Transforming Trauma including:
  1. Create an environment of relative safety.
  2. Support initial exploration of touch sensations including pendulation and titration.
  3. Pendulation: rhythm of contraction and extraction.
  4. Titration: survival based arousal.
  5. Provide corrective experiences.
  6. Uncouple fear from immobility; contain sensation of hyper-arousal.
  7. Discharge and regulate hyper-arousal states.
  8. Engage in self-regulation to restore dynamic equilibrium and relaxed alertness.
  9. Reorient in the here and now.

Resources:

Somatic Experiencing Trauma Institute

http://www.traumahealing.com/somatic-experiencing/index.html

NEUROSEQUENTIAL MODEL OF THERAPEUTICS

Designed to: Structure assessment of child/youth, articulate primary problems, identify key strengths, and apply interventions (educational, enrichment, and therapeutic) to help family, educators, therapists and related professionals best meet the needs of the child.

Components:

- The NMT process helps match the nature and timing of specific therapeutic techniques to the developmental stage of the child/youth, and to the brain region and neural networks that are likely mediating the neuropsychiatric problems.

Resources:

Child Trauma Academy

http://childtrauma.org/index.php/articles/cta-neurosequential-model

MANY MEDICINES:

TRUAMA-INFORMED EVIDENCE-BASED BEST PRACTICES AND PROMISING APPROACHES (PAGE 4 OF 6)

MINDFULNESS

Designed to: 1) Strengthen concentration and increase capacity to focus, 2)

Decrease stress & anxiety and increase sense of calm, 3) Improve immune response and general health.

Components:

Mindfulness activities build skills in:

- Emotional intelligence
- Self-awareness
- Impulse control
- Empathy
- Conflict resolution

Trauma Considerations for Working with Youth:

Be aware that increasing one's awareness of bodily sensations, emotions, and thoughts can potentially be overwhelming to a youth who has experienced trauma.

- Start with simple, non-threatening mindfulness exercises (e.g., focusing awareness on an object in the hand, and if teaching meditation, suggesting only to close eyes if comfortable or look down at a spot in front of them).
- Proceed in a slow, step-wise manner, and check in frequently with youth to ensure that youth feels safe and supported.
- Ensure non-judgmental acceptance of wherever youth is with mindfulness practice.

If youth becomes overwhelmed or triggered, stop the exercise, help youth calm down, then re-evaluate with youth how best to proceed.

Resources:

1. Mindful Schools
   http://www.mindfulschools.org/
2. Mind Body Awareness Project
   http://www.mbaproject.org/
3. Applied Mindfulness
   http://www.applied-mindfulness.org/
4. John Briere Mindfulness Materials
   http://www.johnbriere.com/Mindfulness%20materials.htm

HEALTHY DRUMMING

Designed to: 1) Bridge mind, body, and spiritual realms of self, 2) Decrease stress and anxiety, 3) Induce an awakened and reflective state of consciousness.

Components:

- Participants play basic intuitive rhythmical patterns on a drum, vocalizations, breathing exercises, meditation, and verbal and non-verbal communication.
- Medicinal drumming circles are not music classes and are not focused on learning any traditional rhythms or percussive patterns.

Resources:

Healthy Drumming

http://healthydrumming.org/home.html

HEALING HISTORICAL TRAUMA

Designed to: 1) Increase awareness of unconscious sources of grief and anger, 2) Reclaim traditional mourning, grieving rituals, and ceremonies.

Components:

- Confronting the trauma and embracing history.
- Understanding the trauma.
- Releasing the pain.
- Transcending the trauma.

Resources:

Native American Center for Excellence
http://nace.samhsa.gov/HistoricalTrauma.aspx

MANY MEDICINES

TRUAMA-INFORMED EVIDENCE-BASED BEST PRACTICES AND PROMISING APPROACHES (PAGE 5 OF 6)

NATIONAL CHILD TRAUMATIC STRESS NETWORK (NCTSN)

Designed to: Improve access to care, treatment, and services for traumatized children and adolescents exposed to traumatic events.

Components:

- National Center for Child Traumatic Stress : works with the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop and maintain the Network structure, provide technical assistance to grantees within the Network, oversee resource development and dissemination, and coordinate national education and training efforts.
- Treatment and Services Adaptation Centers : Provide national expertise on specific types of traumatic events, population groups, and service systems and support the specialized adaptation of effective treatment and service approaches for communities across the country.
- Community Treatment and Services (CTS) Centers : Implement and evaluate effective treatment and services in community settings and youth-serving service systems and collaborate with other Network centers on clinical issues, service approaches, policy, financing, and training issues.

Resources:

http://www.nctsn.org

2012 ATTORNEY GENERAL'S TASK FORCE ON CHILDREN EXPOSED TO VIOLENCE

Designed to: Address epidemic levels of exposure to violence faced by our nation's children.

Components:

- Based on public hearing testimony, comprehensive research, and extensive input from experts, advocates, and impacted families and communities nationwide, the final report includes findings and comprehensive policy recommendations to serve as a blueprint for preventing and reducing children's exposure to violence across the United States.

Resources:

http://www.justice.gov/defendingchildhood/index.html

CORE CURRICULUM ON CHILDHOOD TRAUMA

Designed to: 1Expand the nationwide mental health workforce including graduate training programs in social work, psychology, medicine, nursing, marriage and family therapy, and related fields to incorporate trauma-focused approaches to care including strength-based treatment plans that aim to both reduce distress and dysfunction, and promote wellness and positive youth development.

Components:

Basic training for practitioners who lack experience in trauma-focused work and a resource for the continuing education of experienced practitioners to broaden and refine areas of expertise, including:

1. Core Concepts: Basic principles and knowledge regarding trauma-focused treatment including psychoeducation and coping skills.
2. Core Components: Basic treatment elements of trauma- focused treatment including balance between advantages of adhering to a manualized treatment protocol with advantages of tailoring interventions to reflect the specific needs, strengths, and living circumstances of each youth and family.
3. Core Skills: Essential clinical proficiencies in trauma-focused treatment including case conceptualization that centers on empathetic understanding of youth's life and individual trauma experience, rather than only on symptom profile or type of trauma exposure.

Resources:

The National Center for Child Traumatic Stress (NCCTS)

http://www.nctsn.org/resources/audiences/parents-caregivers/what-is-cts/12-core-concepts

MANY MEDICINES

TRUAMA-INFORMED EVIDENCE-BASED BEST PRACTICES AND PROMISING APPROACHES (PAGE 6 OF 6)

NATIONAL CENTER FOR TRAUMA-INFORMED CARE

Designed to: Build awareness of trauma-informed care and promote the implementation of trauma-informed practices in programs and services.

Components:

- Training for staff, leaders, and consumers on the implementation of trauma-informed care in a range of service systems, including mental health, substance abuse, criminal justice, victim assistance, peer support, education, primary care, domestic violence, and child welfare.
- Training is offered either in brief sessions to diverse meeting or conference audiences or over several hours or days to specific programs or agencies.
- Technical assistance and consultation to support systems and programs that are committed to implementing trauma-informed approaches to service delivery.
- Technical assistance helps to identify and implement some of the steps that programs, agencies, or institutions can take to begin the transformation to a trauma-informed environment.

Resources:

National Center for Trauma Informed Care

http://www.samhsa.gov/nctic/default.asp

ACES TOO HIGH

Designed to: Be the go-to site for the general public on news and information about ACEs epidemiology, the neurobiological effects of toxic stress, epigenetics, biomedical effects of ACEs, and how schools, cities, states, agencies, and organizations are implementing trauma-informed practices.

Components:

- Research: Links to current research.
- Resources: Links to useful presentations, backgrounders, reports, and ACE concepts in the news.
- ACEs in Action: Links to projects and programs.
- Our Stories: A place where people can tell their personal stories about how child trauma affected their lives and health.

Resources:

http://acestoohigh.com

AMERICAN ACADEMY OF PEDIATRICS (AAP) MEDICAL HOME FOR CHILDREN EXPOSED TO VIOLENCE

Designed to: Provide pediatricians and all medical home teams with the resources they need to modify practice operations to more effectively identify, treat, and refer children and youth who have been exposed to or victimized by violence.

Components:

- Educational Opportunities: Meetings, webinars, and resources from past events.
- Best Practices and Quality Improvement: Support for ongoing improvement of care within the medical home model.
- Vignettes: Demonstrations in clinical settings to consider exposure to violence as a differential diagnosis.

Resources:

http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Medical-Home-for-Children-and-Adolescents-Exposed-to-Violence/

ACES CONNECTION

Designed to: Be the companion social network to ACEsTooHigh.com for individuals who are implementing, or thinking about implementing practices based on ACE and trauma-informed concepts.

Components:

- Members can post information (text posts, photos, videos, events) directly to the site, "friend" and message others who are doing things of interest, and form groups around interests.

Resources:

http://acesconnection.com

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ADOLESCENT HEALTH WORKING GROUP, 2013

AHWG

www.ahwg.net