Trust/Safety/Engagement in the DJJ Population

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Agenda

- Introduction
- Research Behind the Interaction Between Biology and Environment
- Implications for Trust/Safety/Engagement
Why Me?

- Clinical Nurse Specialist
- 44 years experience- psychodynamic therapy, play therapy, group therapy, trained in CBT, anger management treatment, trauma treatment (4 different treatment modalities). Ran an 18 bed adolescent male inpatient unit- late 80’s and early 90’s. National trainer for Trauma Focused Cognitive Behavior Therapy
- Fascinated with the Decade of the Brain (the 90’s) and with research in child psychiatry
- Switched to outpatient for past 25 years
- Worked extensively with children and families- trained in 5 different parenting models
- Clientele for the last 15 years was predominantly DJJ referrals
Always Start with Research: What Does It Tell Us about Children Affected by PTSD and Complex Trauma?

- Basic Stress response in children
- Orchids versus Dandelions
- Brain Changes with Early Childhood Trauma
- Specific Responses to Untreated Trauma
- Epigenetics- the newest frontier
Quick Review of The Brain’s Stress Responses

* The Cortisol System involves communication via nuclei starting with the Hypothalamus sending hormone producing cells communicating to the Pituitary Glands. The Pituitary Gland then releases a long distance hormone- ACTH- which enters the bloodstream and goes to the Adrenal Glands, which releases cortisol, a powerful hormone that stimulates many effects in the body- including cardiovascular system and the immune system. Put together, this system is call the hypothalamic-pituitary-adrenocortical system (or the HPA axis).
The Fight or Flight Response- the amygdala gets activated under conditions of stress. It sends neurons up to the hypothalamus, which affects the autonomic nervous system (ANS) which produces sweaty palms, dilated pupils, increased heart rate, and tremulousness. It gets us ready to fight or flee.

Both the HPA system and the Fight or Flight system have a great effect on sugar and insulin levels in the blood, blood pressure, heart rate, and the balancing of our immune system responses to threats such as viruses and bacteria, and foreign substances like pollen.

Children who are responding to both acute and chronic stress tend to have higher blood sugar (risk for Type 2 Diabetes), increased blood pressure, greater risk for heart problems and strokes, and shifts in immune function in both directions (either immune suppression or inflammatory responses).
Orchids versus Dadnelions

* Over half the world’s cost for health care (both medical and psychiatric) in children, regardless of country of origin is spent of 15-20% of the world’s children. These numbers carry on into adulthood.

* Study of stress response in children showed that 15-20% of children showed a higher than normal response to stress (increased heart rate, increased breathing, increase cortisol in saliva)- W. Thomas Bryce
Implications Knowing There is a Spectrum of How Children React to Stress Responses

* Many children are resilient, but can still be overloaded with traumatic events.

* The most sensitive children— the orchids—are sensitive to positive interventions as well as stressors. Create a nurturing relationship—unconditional positive regard, empathy, positive environment, positive reinforcement
Brain Changes in Children Exposed to Early Childhood Traumas

- Children exposed to excessive trauma can have brain changes in the size of parts of the brain—particularly the hippocampus.
- They can also have chronic elevated hormones which can impact how they respond to future stressors.
Implications of Brain Changes in Early Childhood Trauma

- Reactions may be hard wired in - difficult to change
- Assist the client to make incremental changes instead of big changes - more like habit extinction
- Address the deficits with skills building following treatment of the traumatic events
Implications in Understanding the Common Reactions to Specific Untreated Traumas

- Sense of Safety

- Ability to Trust - Mistrust may be hard-wired in the brain - can be past from generation to generation; can be a learned early childhood stress reaction; can be exacerbated by the meaning a child makes of their life experiences

- Both of these can interfere with the Ability to Attach to Others
Safety and Trust May Impact Across Several Domains of the Teen’s Life

- Relationships with Caregivers
- Relationships with Peers
- Relationships with Therapists and Counselors
- Relationships with their Environment
Relationships with Their Caregivers

- Multiple Placements is often the rule with this type of client
- Re-enact previous relationships with caregivers
- Push them away before they can be pushed away.
Relationships with Their Caregivers (cont.)

- Conjoint sessions during TF-CBT can often be mini in-vivo experiences around trust, safety, and attachment

- Teach parents Trauma Informed Parenting Skills- why are the behaviors occurring, use of positive re-enforcement before negative, how to respond to micro-aggressions, what to do when the teen is disrespectful, how to handle name calling or cursing, logical consequences versus punishment, how to set a limit when needed
Relationship with Therapists and Counselors

- Re-enactment of previous relationships - Don’t take it personally

- Trust must be established - Set up your relationship from Day 1 based on trust. Educate the teen on why trust and feeling safe may be an issue

- Discuss the possibility of difficulty developing a relationship

- Don’t get into battles
Relationships with Therapists and Counselors (cont.)

* Create a safe, nurturing environment- unconditional positive regard
* Give honest, clear responses
* Use empathy and choice
Trust involves adherence to consistency- don’t change the rules- consistent times, stay with the boundaries of the session, try not to cancel appointments

Creating and maintaining a nurturing environment- include a wide variety of treatment resources for different likes and developmental capacities of the the youth
Relationships with Peers

* “I don’t have friends. I have associates.” - how client perceives their environment and relationships in them.

* Misperception of Cues

* Poor Problem Solving

* Re-enactment of their traumas
Relationship to their Environment

- More Triggers- neutral facial expressions do not always come across neutral; loud voices;
- May re-enact their traumas- i.e. neglect, physical abuse, or domestic violence
- Staff, therapists, and caregivers need to know how to handle micro-aggressions
Handling Micro-aggressions

* Catch it early- “Am I safe? Are others around my client/teen safe?”

* If possible, start with lower level interactions less likely to set off power struggles- Statements of Concern, Negative Inquiry, Negative Assertion (Validation of all or part of what someone is saying), Reflection, Active Listening

* Don’t get side tracked with how they are saying it. Ignore, dismiss, or re-direct if client curses or calls you names.
Handling Micro-aggressions (cont.)

- Avoid the word “but” if possible.

- Recognize your own triggers and reactions. Often based on your own core beliefs—“I won’t be talked to like that.”—can initiate a battle.

- If you need to set a limit, whenever possible do it with empathy and choice.
Handling Micro-aggressions (cont.)

* Don’t go to problem solving too quickly. It needs to be done after affect is expressed in a healthy way.

* If need be, go back to the lower level interactions.

* Reminder of Consequences and show/use of force should be judiciously used.
Case Study #1 - Devon

* Devon was a 16 yo biracial male who was ejudicated and placed on house arrest after multiple assault arrests and convictions. He wore an ankle monitor and had been court ordered to attend outpatient psychiatric treatment, specifically trauma treatment. Records indicated that he was born into an inner city family where there was a lot of chaos in the environment. Mom and Dad were drug addicts. It was unclear whether or not Devon was exposed in utero to drugs and alcohol. He lived with mom and dad for the first 3 years of his life, and was removed after he came to his Head Start Program with multiple bruises on his body. Dad was arrested soon afterwards on a drug charge, while Devon was living with a foster family. Mother got herself into treatment, and was able to reunify with him after a year’s separation. They lived in a dangerous inner city environment, where Devon was exposed to multiple episodes of community violence, including 1 shooting, 2 stabbings, and multiple muggings.

* Mother then became involved in a relationship with an abusive boyfriend when Devon was 6 years old, and he witnessed domestic violence for the next 3 years. It culminated in him, at the age of 9, witnessing mother stab her boyfriend, and she was arrested and sent to prison. The aunt again became his legal guardian.
Devon- (cont.)

- He did fairly well for about a year. He had changed schools and was passing. He reported some conflict with peers, but seemed to be adjusting. At the age of 11, however, he was expelled from his school for bringing a knife to school. He then started on a downhill trajectory with multiple arrests for aggression and assaults. The last assault resulted in severe injury to his victim.

- Upon intake, he presented as shut down and with flat affect. He did not think that treatment was needed, and was just attending so that he could “stay out of jail.” He had no trouble explaining the superficial details of “what happened” when mom stabbed her boyfriend and was arrested. Aunt presented as hopeless, at her wits end, thinking that nothing was going to work.
Implications of Trust and Safety for Devon

* Caregiver- instilling hope, understanding his numbing, understanding how her parenting skills needed to be adapted

* Peers- may misperceive cues; may have difficulty developing friendships, poor problem solving

* Therapists/Counselors- established a safe nurturing environment in the office; maintained a consistent time weekly; maintained the boundaries of time; unconditional positive regard, used empathy and choice, did a lot of psycho-education on implications of their trauma history; did conjoint sessions around the possibility of them being triggering; maintain transparency and honesty; roll with resistance whenever needed;

* Environment- is it safe and nurturing; how are micro-aggressions handled; if behavioral interventions are use, are they mostly positive reinforcing; do they place the direct care staff/caregivers into roles as enforcers versus cheerleaders?
Case Study #2 - Isabella

- Isabella was a 13 yo Hispanic female who had been previously arrested for multiple petty crimes. Her most recent crime was an armed robbery, where a store owner was shot, and she was sentenced to a residential treatment detention facility.

- Early childhood trauma history revealed that both mom and dad had mental illnesses. Mom had a diagnosis of bipolar disorder, and Dad had a diagnosis of schizophrenia. Isabella was removed from her parents at the age of 5 years old, when she and her 3 year old brother were found left unattended in a crack house. They were emaciated and unkept. Isabella had chlamydia. Both were developmentally delayed. They lived with an aunt and uncle for 3 years during which time they were both physically abused.
Thus started their entry into Department of Social Services, where they were placed in numerous homes without success.

The brother was eventually adopted, but the family could not manage Isabella, and she was separated from her brother. There was an unsubstantiated report of sexual abuse at one of the foster homes when she was 10 by a 17 yo foster sibling. Lying, stealing, and aggressive behaviors increased, she started using marijuana and cocaine, and by the age of 13, she was sentenced to a detention treatment facility.

Upon intake, Isabella was guarded and angry. She cursed a lot and refused to engage in treatment. She was getting into trouble for conflicts with peers on the unit, and was oppositional with staff.
Implications for Safety and Trust for Isabella

* Don’t take the client’s behaviors personally
* Establish unconditional positive regard
* Use techniques for managing micro-aggressions
* Roll with resistance
Implications for Safety and Trust in Isabella (cont.)

- Set up boundaries as needed—there will often be testing by this type of client
- Be transparent and honest; may need to repeat rationale for why you are doing gradual exposure more than once
- Maintain empathy
- Allow choice whenever possible
Thank-you!

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