Treating Trauma in the Family Setting

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PINNACLE FAMILY SERVICES

Families & Trauma

ADDRESSING TRAUMA WITHIN THE FAMILY SYSTEM

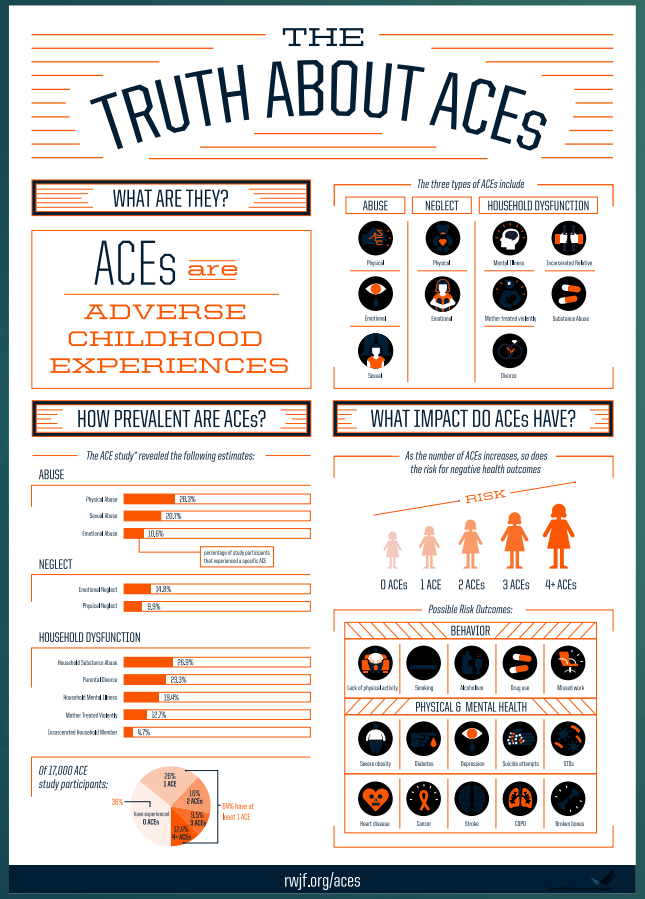
What is Trauma?

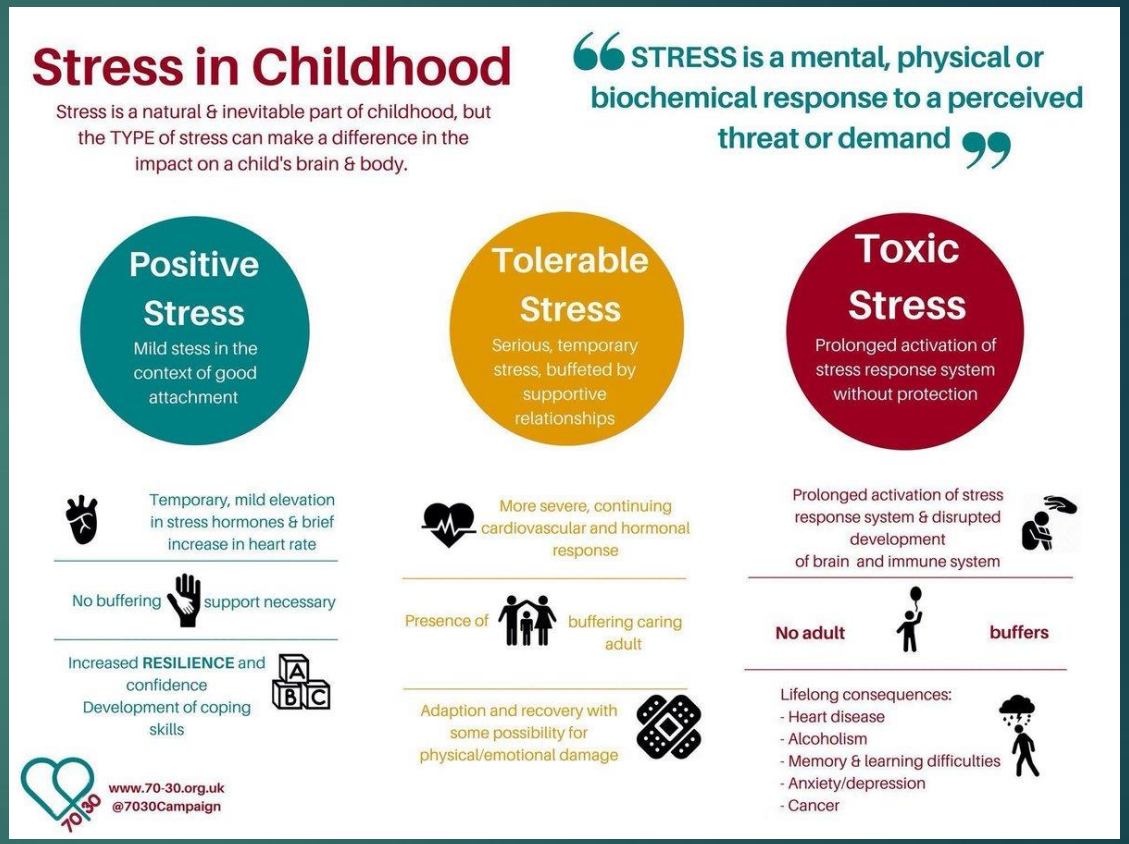
The word *trauma* is used to describe negative events or experiences that are emotionally (and/or physically) painful and that overwhelm a person's ability to cope.

The types of trauma that tend to have the greatest adverse psychological consequences are those related to interpersonal or intentional trauma.

Trauma by other names…

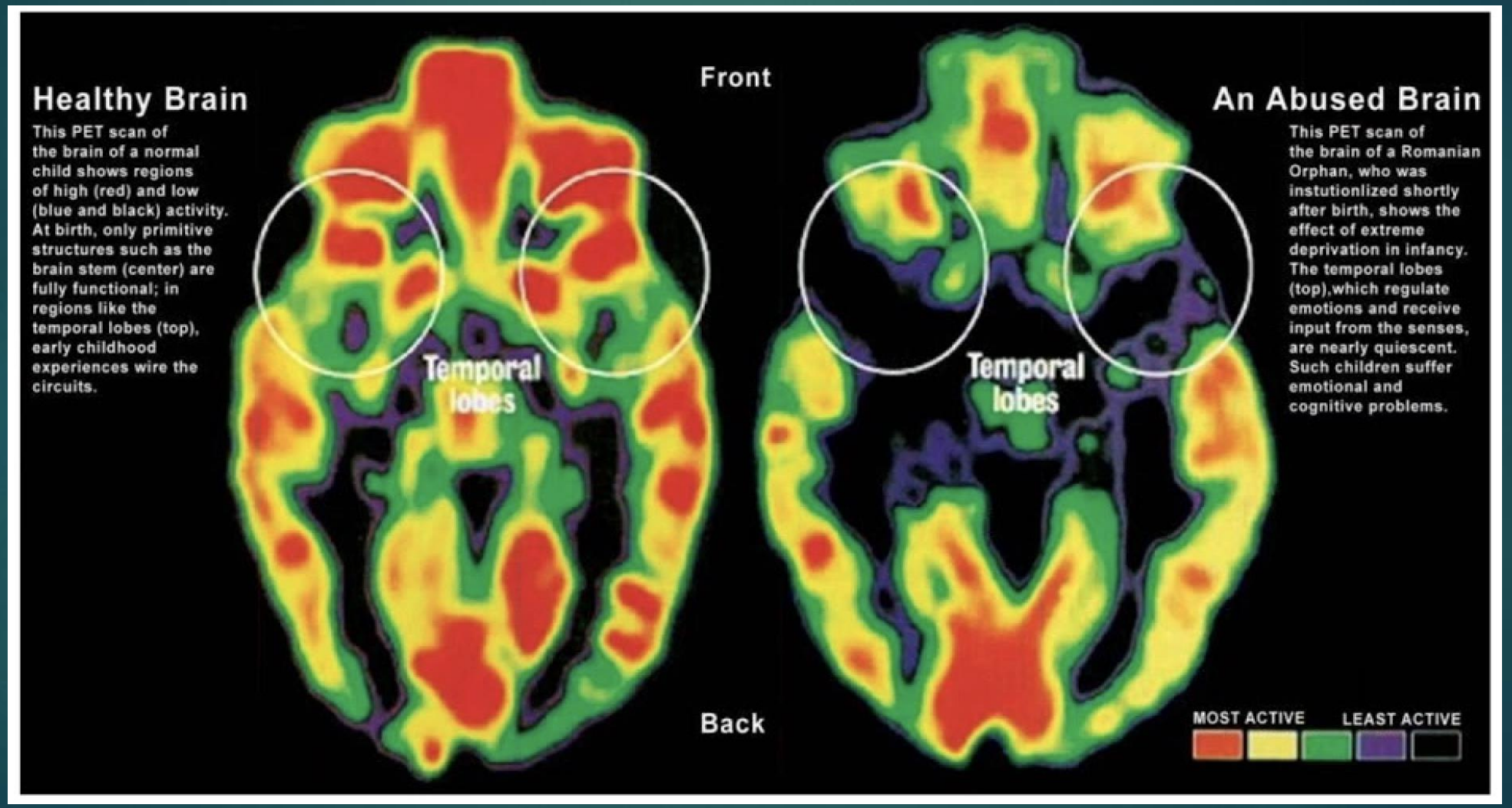
"An ACE score of 4 or more makes children 32 *times as likely* to have problems in school."
~Dr. Nadine Burke Harris





"We coined the term *toxic stress* to try to explain to people how there is stress and there's **STRESS**. Toxic stress is the chronic activation of stressors with no buffering protection, no support." ~Dr. Jack Shonkoff, Harvard University

Trauma, the brain, & neuroplasticity…

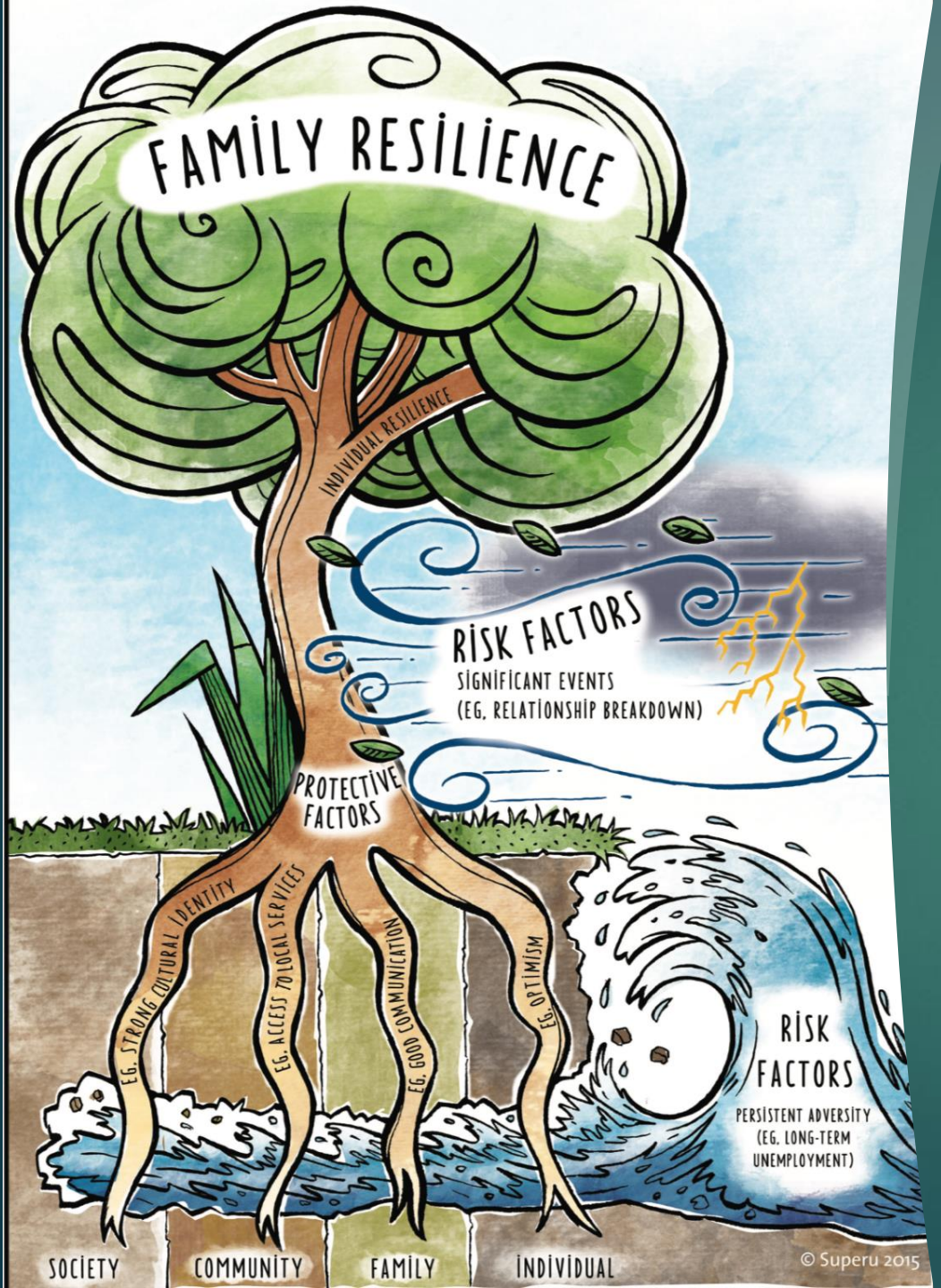


Neuroplasticity:

The ability of the brain to reorganize itself, both in structure and how it functions.

- *Neuroplasticity makes your brain resilient.*
- *Neuroplasticity enables you to recover from stroke, injury, and birth abnormalities.*
- *You can learn new ways of being and responding to conflict.*
- *In many cases, you can also overcome depression, addiction, obsessive compulsive patterns, ADHD, and other issues.*

Source: National Institute for the Clinical Application of Behavioral Medicine (NICABM)



How Does Trauma Impact Families?

- All families experience and respond to trauma differently, based in large part on a variety of individual, family, community, and societal-level protective and risk factors.
- Risk factors contributing to negative outcomes generally include prior individual or family psychiatric history, history of other previous traumas or adverse childhood experiences, pile up of life stressors, severity/chronicity of traumatic experiences, conflictual or violent family interactions, and lack of social support.

Source: National Child Traumatic Stress Network (NCTSN)

EXAMPLES OF INDIVIDUAL FAMILY MEMBER FACTORS	EXAMPLES OF FAMILY FACTORS
Protective: • Positive Coping • Behavior/Anger Control • Optimism/Hopeful Outlook Risks: • Mental health issues • Unemployment/low income • Lack of Confidence	Protective: • Good Communication • Clear Roles • Secure Household Income • Effective Decision-Making Process Risks: • Family Violence • Over-dependence on each other • Relationship breakdown • Parentification of youth
EXAMPLES OF COMMUNITY FACTORS	**EXAMPLES OF SOCIETAL CHARACTERISTICS** (Economic, Social, Cultural, Environmental)
Protective: • Sense of Belonging to Community • Community Cohesion • Opportunities for Community Involvement • Safe Spaces to Gather Risks: • Isolation • Facing Community Prejudice • Economically Deprived Community • Community Violence	Protective: • Social Norms that Promote Healthy Relationships • Strong Cultural Identity and Pride • Policies that Support Families Risks: • Limited Economic Opportunities • Norms that Condone Violence • Natural Disasters

Source: Social Policy Evaluation and Resource Unit, New Zealand

How can we best support families experiencing traumatic stress?

- Help families access supports and treatments that focus on all family members and work to stabilize the whole "family unit". Look for ***evidence-based, family-informed trauma treatments*** that:
  - Put families in the "driver's seat" and empower them to plot their own courses of recovery and healing
  - Build meaningful partnerships that create mutuality among children, families, caregivers and professionals at an individual, organizational, and community level
  - Optimize the strengths of the family's cultural or ethnic background, religious or spiritual affiliation, and beliefs to support recovery
  - Educate families on the signs of posttraumatic stress and how it can affect the family
  - Identify and address unresolved trauma with all family members
  - Identify and strengthen impaired areas of family functioning

A national model for treating trauma in the family setting.

FAMILY CENTERED TREATMENT®

Family Centered Treatment is an evidence-based model designed to work with the entire family system, identifying and addressing trauma individually and within the family system throughout treatment.

The Family Centered Treatment Foundation recently received a SAMHSA award sponsored by the National Child Trauma Stress Network (NCTSN) to fund the ***Family Centered Treatment Trauma Series Project*** with the following goals:

- expand the trauma treatment components of its existing FCT model
- enable thousands of youth and families experiencing trauma to obtain evidence-based family-systems treatment
- collaborate nationally with other providers of trauma treatment

"We in the National Child Traumatic Stress Network are thrilled to have the Family Centered Treatment Foundation join our network! We appreciate the expertise FCTF brings as well as their willingness to collaborate with the other network centers on behalf of children and families experiencing trauma and traumatic stress." ~ Chris Foreman, NCTSN Liaison.

The Four Phases of Family Centered Treatment®

Joining and Assessment

During this phase the clinician engages the family and gains acceptance and trust. The family centered evaluation is utilized to determine areas of family functioning that need adjustment.

Indicator for Transition: The family begins to carry out the clinician's suggestions and assignments indicating trust in the process.

Restructuring

The clinician and the family use enactments (experiential practice experiences) to alter ineffective behavioral patterns among family members. This process includes techniques to modify the crisis cycle to more effective and adaptive patterns of family functioning. If emotional blocks, due to past or present trauma, prohibit compliance with practicing new behaviors, the clinician engages the family or specific members into trauma treatment, via emotion change techniques, rather than behavioral approaches.

Indicator for Transition: Successful enactments lead to earnest questions by the family members regarding what they can do differently to change/break their maladaptive patterns. These questions are an indicator that the ownership of problems is now seen as a family issue, rather than placing the blame on an individual family member. When the practicing of new interactions begins to produce behavioral changes, the clinician moves to the next phase.

Emotional Blocks / Trauma Treatment

With clinician guidance, the family determines coping and supportive behaviors to address traumatic histories. They are guided to identify and practice effective methods for meeting emotional needs.

Valuing Changes

The clinician adjusts their style and methods in order to challenge the intent and reason for the behavioral changes that the family has made. The family evaluates and defines the reasons for their changes. Family members integrate new behaviors into their personal value system, determining changes to sustain based on what is working for them.

Indicator for Transition: The family is no longer merely conforming or complying with directions, but is following through on suggestions and expanding upon them to meet their own needs. Although crisis may still continue, the family tells the clinician how they handled the situation using their newfound skills, rather than asking the clinician what to do.

Generalization

With new skills for dealing with conflict and increased understanding of their own dynamics, the family continues its work, but the treatment is less intense and frequent. The clinician's focus is continued "practice", review of what has "worked" previously, and use of "reversals."

Indicator for Transition: New skills have become internalized and new responses to crisis are becoming patterns. Once in this phase the family will be ready for discharge within 30 – 60 days.

Family Centered Treatment® Areas of Family Functioning

Problem Solving	*Goal: Successful achievement of a variety of basic, developmental, and crisis tasks.*	1. Task or problem identification and communication about the problem 2. Exploration of alternative solutions 3. Implementation of selected approaches 4. Evaluation of effects
Communication	*Goal: Mutual understanding is reached*	1. Clear and Direct: concise, understood and to the intended recipient 2. Clear and Indirect: concise but spoke to another person 3. Masked and Direct: message clouded but target person is clear 4. Masked and Indirect: message and target person are ambiguous
Role Performance	*Goal: Role interpretation*	1. Allocation and Assignment to family members 2. Agreement and Willingness to fulfill role 3. Enactment to carry out behavior of role
Affective Responsivness	*Goal: The expression of welfare and emergency emotions; affection, warmth, support, fear, anger, disappointment*	1. Content- broad range available to discuss 2. Intensity- good match of intensity to situation 3. Timing- given at appropriate time4. Most likely to be a problem in time of stress
Affective Involvement	*Goal: Security and Autonomy*	1.Uninvolved family – no interest or investment in one another; devoid of feelings- some interest, but little investment 2. Narcissistic - some feelings for each other but for self gain 3.Empathetic family- able to meet emotional/security needs of each other, flexible 4. Enmeshed- over intrusive, over protective
Behavioral Control	*Goal: Maintenance and Adaptation, influence over one another*	Family's management style in physically dangerous situations, meeting psychological needs & socialization behaviors. 1. Predictive vs Inconsistent 2. Constructuve vs Destructive 3. Responsible vs Irresponsible 4. Lead-Ins to one of the styles: rigid, flexible, chaotic, etc

Assess all areas of Family Functioning that are deficient

Adapted from: Evolution and Treating Families: The McMasters Approach; Ryan et. Al (2005)

Building Resilience & Addressing Family Trauma with FCT

- Solution Cards – strategies for handling stress and/or triggers
- Ecomaps – visual map of supports & stressors
- Family Life Cycle – Guiding the adults in identifying family patterns, including those that are healthy "keepers" and those that can be "let go"
- Structured Family Assessment – an assessment involving the whole family which includes mapping 3-generations of the family, getting family agreement on a shared goal, commitments to work on that goal together, and feedback on the process.
- Family Centered Evaluation – the document that synthesizes all of the above into a map for treatment for the family over the next several months
- Addressing Emotional Blocks – identifying and addressing underlying trauma and its impacts as they arise throughout treatment
- Family Giving Back Project – the family identifies a service project that they will work on together to give back to their larger community

Family Life Cycle

Date:

Name:

1. CHILDHOOD	ADOLESCENCE	YOUNG ADULT	ADULTHOOD

2. How has your experience influenced your parenting?

3. How was your FLC experience?

4. LETS MAKE A PLAN

What do you want to keep (do the same as you experienced)?

What do you want to make different?

What do you want to make new?

Intervention #18: SODA (Shaking Off and Diffusing Anger)

Purpose: Families will engage in discussion about appropriate anger management, look for new strategies and open a dialogue around understanding cues and signals. Family communication can be enhanced by learning about the cues as well as appropriate management of anger. Also, just a fun way to engage family members around a sensitive topic.

Materials Needed:

a soda (in cans) for each member of the family—age appropriate. Parts of this activity should only be done outdoors.

Instructions:

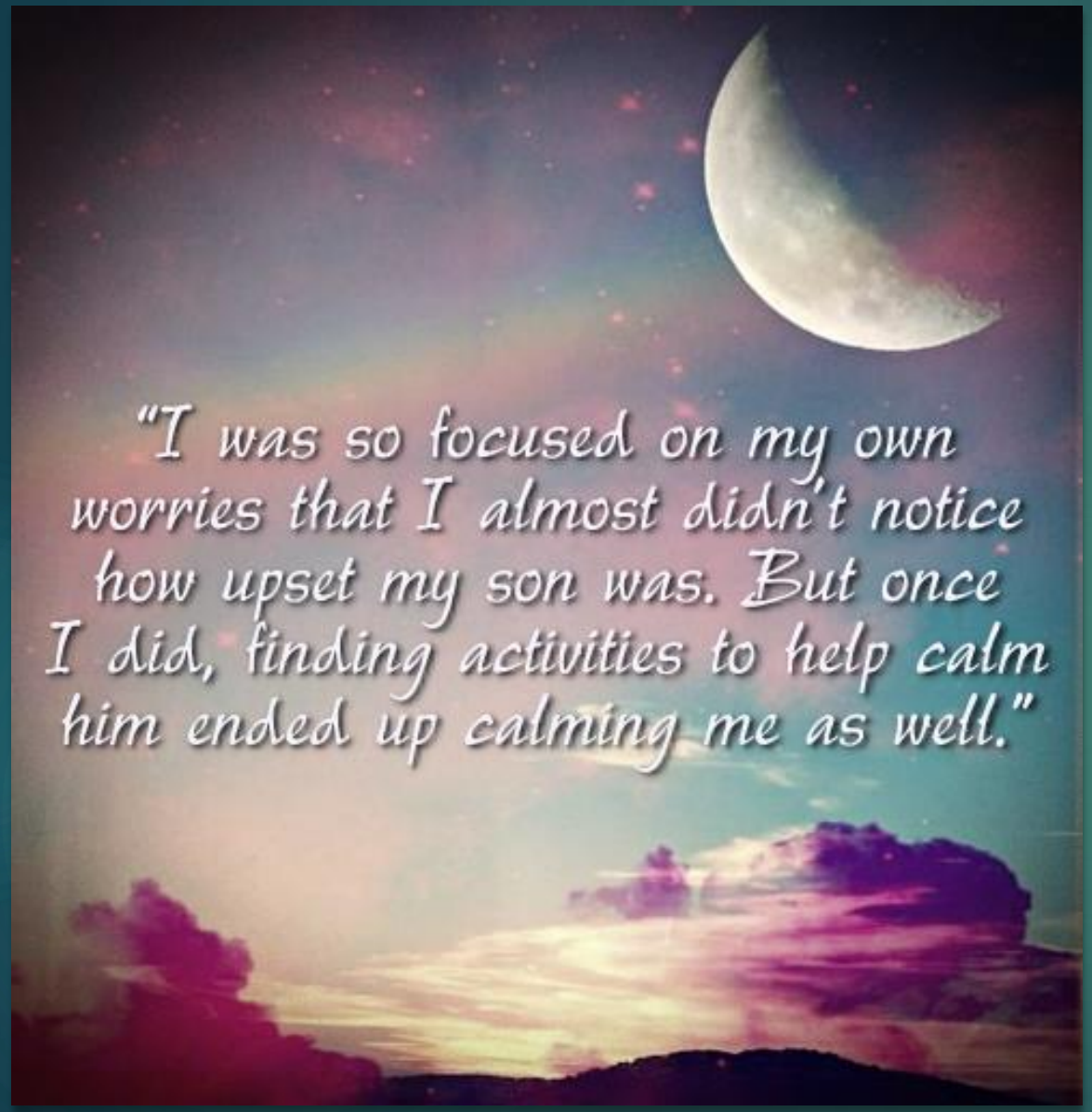
Clinician will offer the soda to one family member, shaking it up before it is handed to the family member

Clinician will invite the family member to open the can to enjoy the soda. Family member will not open the can because the soda will spray all over the place. Clinician will engage family member in discussion around consequences of the soda explosion—(i.e., it will get all over the place, can ruin clothing, make things sticky, and will lose half of the soda).

Clinician will discuss with the family about anger and learning to control anger before it spills all over and creates unwanted consequences. This can lead to a discussion on how to keep the feelings from blowing up, escalating, and appropriate use of feelings when escalation has already happened.

Clinician will explain that soda pressure will only be high for a while (usually a few days). After it has time to settle, the family can enjoy the sodas together or at the next family session. Each can will be marked by the family so everyone has their own; and to distinguish it from other cans (as to avoid someone opening it and it exploding its contents and making a mess). This can also lead to a discussion on recognizing when others are angry—(what signs and signals do each family member show to put out that they are angry).

Clinician should prepare ahead of time with the family head to explain the concept and to gauge appropriateness of activity. If a child is less likely to cooperate, FCS should use good judgment when asking a specific family member to participate. If appropriate, Clinician can do this activity outside and show what happens to contents of the soda as it is shaken up. Again, clinical judgment should be used to measure appropriateness and how this intervention can be used most effectively



Calming The Storms

TEACH AND USE TECHNIQUES WITH FAMILIES TO REFOCUS & CALM EACH OTHER, BEFORE THE STORM HITS…

Fostering Solutions

TREATMENT FOSTER CARE

Two Treatment Foci and
2 Key Concepts
Trauma-Informed and
Relationship-Focused Care

What is Trauma-Informed Care?

"Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives."

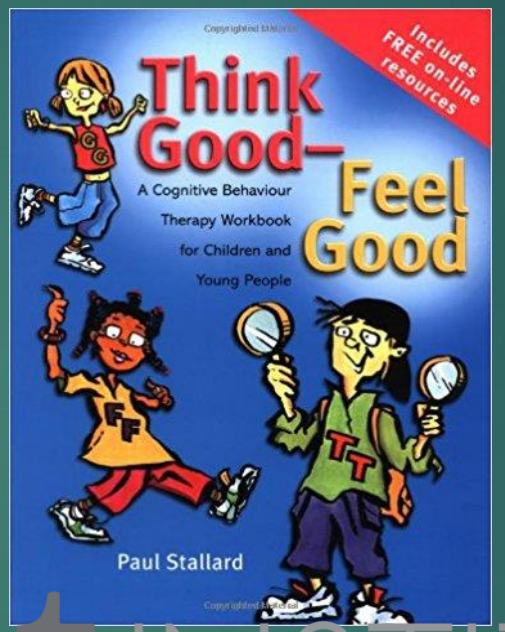
-SAMHSA – National Center for Trauma-Informed Care

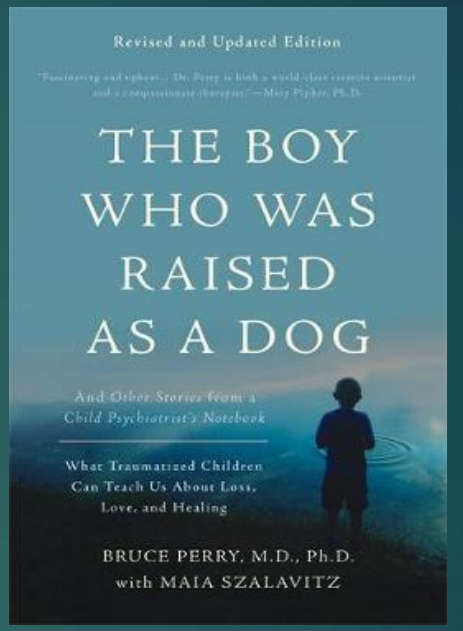
What is Relationship-Focused Care?

Relationship-focused care is an approach to helping children, youth and their families that recognizes the connections between a child and any caregiver as a healing dynamic able to produce as dramatic and profound effects on a child's well-being as any formal intervention system.

Fostering Solutions influenced by…

- Dr. Bruce Perry
- Bryan Post
- Paul Stallard





PostINSTITUTE

Solutions for Parenting Challenging Children

Fostering Solutions Fidelity Components

- Increased Clinical Consultation with Foster Parents
- Solutions Cards developed on day of placement
- Case Introduction and EcoMap
- Monthly Health & Safety Interview
- Safety Plan
- Strengths & Resources Inventory

Fostering Solutions Fidelity Components Continued

- EcoMap with Foster Parent
- MIGS staffing
- Pediatric Symptom Checklist at admission and discharge
- Shared Parenting Plan with activities happening at least monthly
- Successful Adaptation Checklist

Solution Cards

- ASSISTS BOTH THE YOUTH AND FOSTER PARENT IN IDENTIFYING TRIGGERS
- ASSISTS BOTH THE YOUTH AND FOSTER PARENT IN DEVELOPING STRATEGIES WHEN TRIGGERS OCCUR TO AVOID DEVELOPMENT OF CRISIS
- COMPLETED WITH THE YOUTH WITHIN 7 DAYS OF PLACEMENT
- REVIEWED AND REVISED AS NEEDED WITH EACH CRISIS EVENT
- COMPLETED WITH THE FOSTER PARENT INITIALLY PRIOR TO FIRST PLACEMENT
- FOSTER PARENT SOLUTION CARD IS REVIEWED AND REVISED AS NEEDED WITH EACH PLACEMENT

Solution Cards Activity

QUESTIONS?

Many thanks for your time & attention!
For more information or to make a referral visit:
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or email us at:
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