Children's Mental Health Matters

Number 10, April 2013

The Trauma-Informed Checklist

By Gordon R. Hodas, M.D.

Introduction

This column focuses on how well-meaning mental health and other human service professionals can assess whether or not they are being trauma-informed in their relationships with *individuals* (primarily referring here to youth and their families). Two earlier columns have described the prevalence and significance of childhood trauma (Hodas, 2012a), and how trauma-informed care represents a public health approach to help prevent re-traumatization and promote healing (Hodas, 2012b).

Professionals who do not recognize and address trauma in their work with individuals may unintentionally engage in what is known as system-induced trauma. The latter involves trauma inflicted by mental health and other human service systems on individuals, which exacerbates their pre-existing trauma (NCTSN). System-induced trauma may result from acts of commission (e.g., inappropriate and unnecessary use of seclusion and restraint) and from acts of omission. One of the prime examples of system-induced trauma by omission involves failure to consider the impact of trauma on the presentation and functioning of the individual. When trauma is not recognized and addressed in individuals presenting with complex challenges, progress is likely to be limited, and harm to the individual may occur (Jennings).

In mental health and human services, professionals need to form *therapeutic relationships* with those with whom they work (Hodas, 2006). This means that relationships need to benefit the individual therapeutically, not that the staff person is doing therapy. In human services, the significance of the therapeutic relationship parallels the importance of important relationships throughout the life cycle. For example, infants cannot survive without a committed, caring parent or caregiver. Students typically cannot learn unless they experience their teacher as being committed to them. Youth need at least one positive role model to effectively navigate the challenges of adolescence. In each instance, the sustaining relationship is not perfect, but is characterized by caring, consistency, and persistence.

Trauma-Informed Care

Trauma-informed care is a vehicle to guide professionals in being respectful and therapeutic with those with whom they work. Trauma-informed care needs to be part of an organization's values and culture, and needs to be offered to agency staff and not just to individuals (Bloom; Fallot and Harris, 2009). At the individual level, trauma-informed care is best understood as involving ongoing interactions between a professional and the individual that are therapeutic in nature, as experienced by the individual. Trauma- informed care is guided by five core principles (Fallot, 2011; Fallot and Harris, 2009): 1) safety (physical and emotional), 2) trustworthiness, 3) choices, 4) collaboration, and 5) empowerment. The latter is promoted via a combination of validation, respectful guidance, and the teaching of specific coping and life skills.

Children's Mental Health Matters is a monthly column to support children, adolescents and their families from the Office of Mental Health Services, Bureau of Children's Behavioral Health Services. It is available online at www.parecovery.org and can be printed and distributed as desired.

The Trauma-Informed Checklist

Delineation of the five core trauma-informed principles is important, but in a practical way how can professionals determine whether or not they are being trauma-informed? In what follows, I offer a "Trauma-Informed Checklist" that professionals can use for self-assessment, one individual at a time. I developed this checklist to assist me in clinical work with youth and families, and to help others in need of a reflective tool to think about trauma-informed care at the individual level (Hodas, 2011).

Below are the questions on the trauma-informed checklist :

- Am I committed to promoting the safety of others? Am I *effective* in promoting their safety?
- Do I want to guide and empower others, or do I want to control them?
- Am I respectful and trustworthy in my interactions with others, even when there is disagreement?
- Do I mostly listen, or do I mostly preach to others?
- Do I use power or threats to gain "compliance," or do I try to engage and motivate others, so that we can work together and collaborate?
- Do I use my hands to restrain others, or to hug them, when appropriate?
- Do I try to understand why a person is struggling, including by considering issues of trauma, or do I focus primarily on their behaviors, "pathology," and diagnosis?
- Can I identify how a person's challenging behavior may have supported their survival in the past, and perhaps may continue to serve this function?
- Am I able to offer hope to others without disqualifying the reality of their life experience to date?
- Am I able to identify strengths in others and help them recognize these also?
- Do I encourage others, consistent with their age and developmental level, to think positively about their life, exercise personal choice, and identify positive goals?
- Do I help others learn to express themselves, advocate for themselves, and develop other important life skills?
- Do I follow the five core TIC principles in my interactions with other professionals and with my colleagues, supervisor, and others?
- Do I model the five core principles in my interactions with parents, guardians, and other family caregivers, to help them learn how to do this with their children?
- Do I know key resources to help the population with which I work, and do I help individuals and families identify and engage natural community supports?
- How do I answer the "Cardinal Question": Do my clients see me as truly being "on their side"?

Discussion

It should be evident that the questions comprising the Trauma-Informed Checklist all build on the five trauma-informed principles identified above. One self-assessment question inquires not about the individual relationship but rather about the professional's relationships with peers and supervisors. While this may seem to involve a different area of inquiry, it is included because one's relationship with individuals depends in part on the quality of one's relationships with other involved staff.

The purpose of the checklist is to stimulate reflection, remind the professional of the broadly-based implications of trauma-informed care at the relational level, and support trauma-informed behaviors by the professional in the individual relationship. These same questions, judiciously selected and rephrased, may also be posed to the individual directly. For example, the professional can ask the youth, "When we talk, do you feel that I listen carefully to what you are saying?" The discussion with the youth, however, will be of greater benefit if the professional has first engaged in his or her own self-assessment. Given that trust and the ability to discuss personal relationships are often difficult for those with significant challenges, the direct use of the checklist with individuals can represent a constructive way to model safe discussion of important issues.

Conclusion

Trauma-informed care, including trauma-informed relationships, needs to be the standard of care in human services. Providing trauma-informed relationships helps the individual overcome some of the adverse affects of past trauma: lack of safety; distrust and possible feelings of betrayal; coercion and absence of choice; uncertainty regarding what will happen next; and disqualification and humiliation in response to efforts at self-assertion and self-advocacy. The Trauma-Informed Checklist can be used for professional growth and quality enhancement, and also serves as a potential catalyst for discussion of the relationship with an individual This tool can help professionals be truly therapeutic, In using the tool, the professional needs to be curious, non-defensive, and open to change. While efforts to provide trauma-informed care are admirable, the professional needs to bear in mind that, ultimately, the effectiveness of trauma-informed care is in the eyes of the beholder.

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