Developmental Trauma & Youth Violence

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Treating Complex Trauma within Systems of Care
Chicago, IL
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Scope of Problem

Homicide is the…

- #1 cause of death among African Americans ages 15-34
- #2 cause of death among Hispanics
- #5 cause of death among non-Hispanic whites

≈ 156,000 incidents of violence against African American males ages 15-34 were treated in hospitals

- ≈1 out of every 40 young men in this demographic group

Violent injury is a recurrent problem

- Five year re-injury rate as high as 45%
- Five year mortality rate as high as 20%

2011 National: CDC Injury Prevention & Control: Data & Statistics (WISQARS). Nonfatal Injury Data

Violent Injury is a Reoccurring Disease

Cunningham et al., 2015

Patients 14-24 presenting to Urban ED (Flint, MI)

24-Month Reinjury Rate

Assault-Related Injury Patients	36.7%
Non-AI Patients	22.4%

Chong et al., 2015

Patients 12-24 presenting to Urban ED (East Bay)

Risk Factor	OR
Male	2.24
Black/African American	2.14
Firearm Injury	2.28
Public Insurance	1.56
Low SES Neighborhood	1.48

Comer Children's Hospital Trauma Stats FY2015

	N=264	%	Other Pediatric Hospitals 2012 %
Assaults (non-abuse)	70	26.5	5.4
Abuse	11	4.2	
Penetrating Injury	66	25	3.4
Firearm	56	21.2	1.2
Deaths	6	2.3	1.01
Firearm-Related Deaths (includes 1 MV vs Peds)	5	N/A	N/A
Firearm-Related Injury Survivors	52	N/A	N/A
Assault Survivors	66	25	N/A

83% of deaths were firearm-related.

93% of children injured by firearms did not die.

Average Cost for Care of Patient Discharged from ED	$6,000
Average Cost for Admission from ED	$15,000
Average Cost for Care of Gun Shot Wound Patients	$70,000+

Scope of Problem

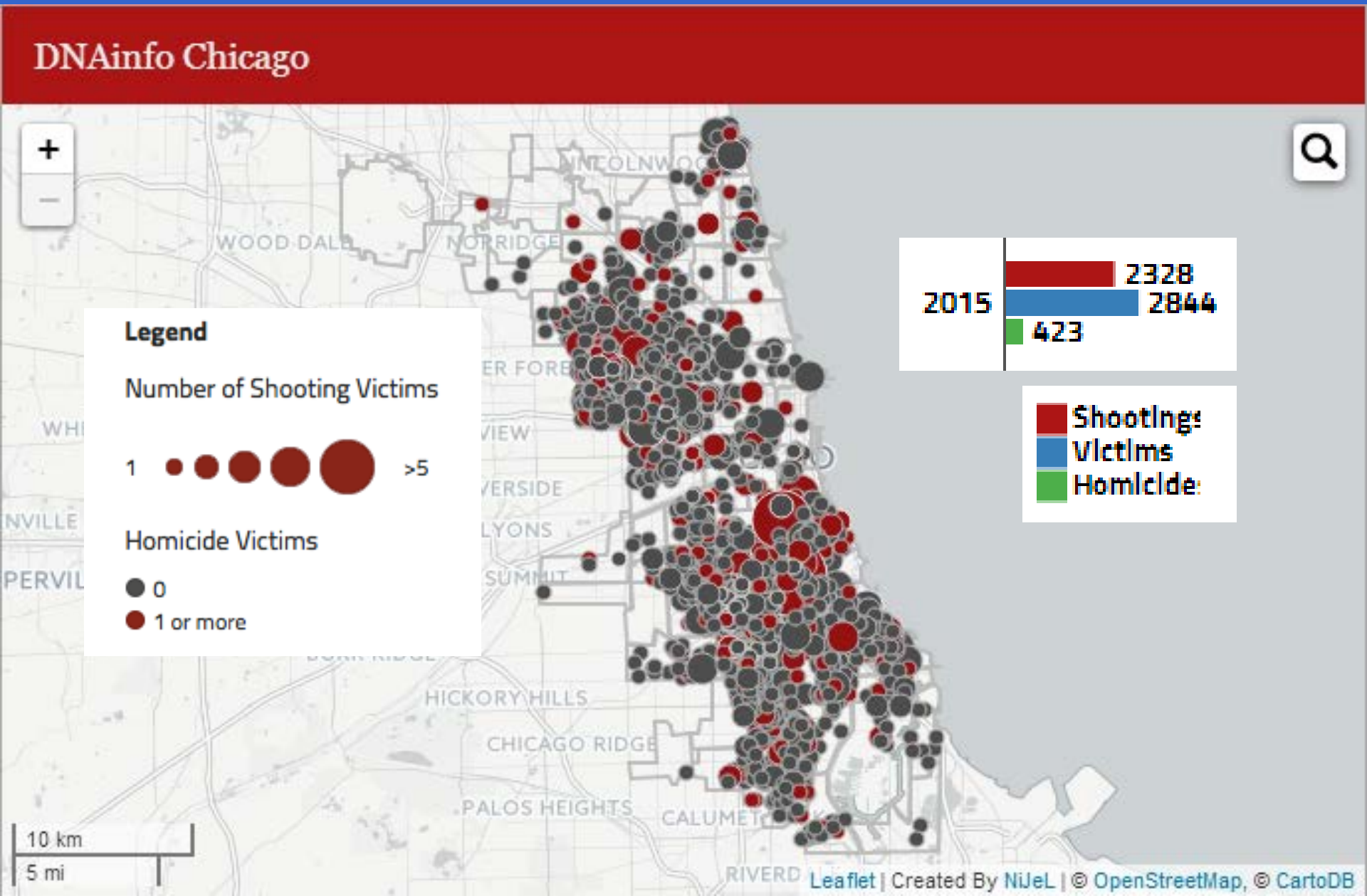
Chicago 2016

523 Homicides

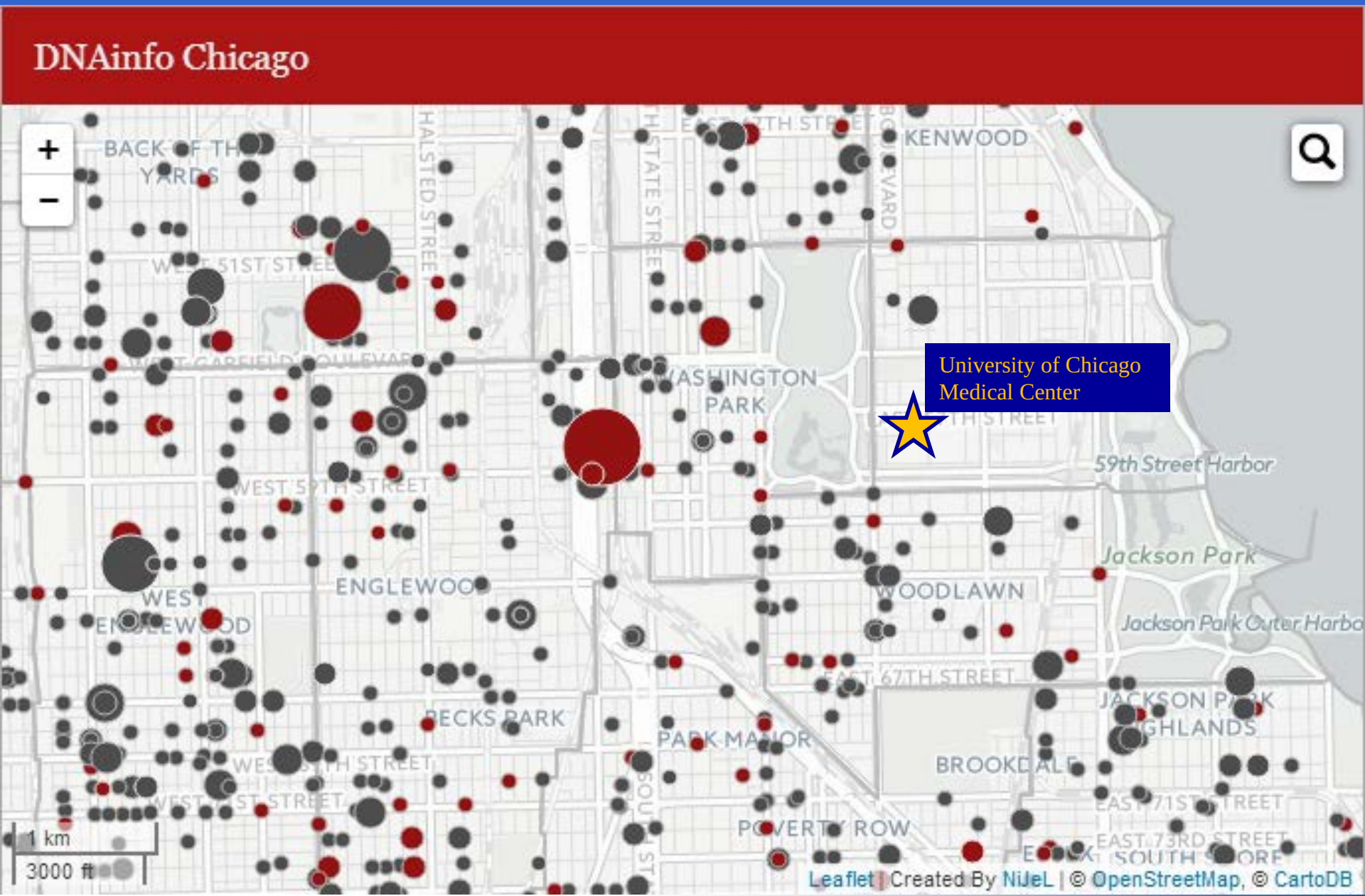
3,062 Shooting Victims

HHP-C received 41 referrals in August alone.

Shootings in Chicago 2015



2015 Shootings in Chicago



Eighty percent of patients presenting to the Comer ED reside in a 10 Zip Code area in a 6-mile radius around UCM. All 10 of these Zip Codes are home to majority African American populations, with 7 of the 10 being at least 95% African American. As a whole, the population of this 10 Zip Code area is 87% African American, 6% White, and 6% Hispanic/Latino. In contrast to the overall city of Chicago (51% female), this area is 55% female, the result of life expectancy disparities and mass incarceration. Over 35% of the population

in this area is below poverty, more than 1.5 times the 22% rate for the 45 other Zip Codes in the city of Chicago. The unemployment rate for the population aged 16 years and older in this area is 9.1%, more than 1.6 times the rate for the 45 other Zip Codes in Chicago (5.4%).

Adverse Childhood Experiences Study (ACES)*

Physical abuse by a parent

Emotional abuse by a parent

Sexual abuse by anyone

An alcohol and/or drug abuser in the household

An incarcerated household member

Someone who is chronically depressed, mentally ill, institutionalized, or suicidal

Domestic violence

Loss of a parent

Emotional neglect

Physical neglect

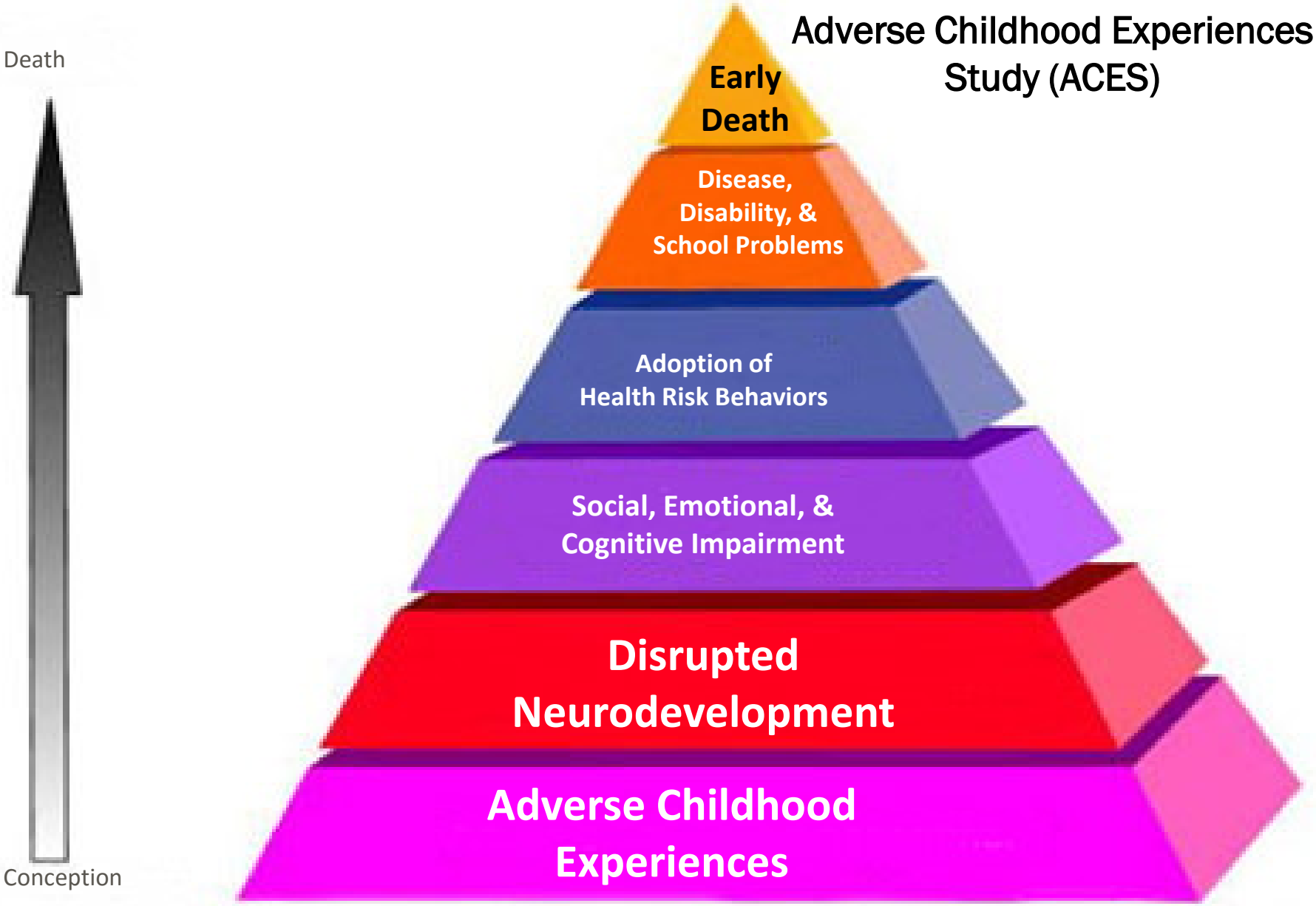
Felitti et al. 1998

Trauma and Outcomes

Adverse Childhood Experiences Study (Anda and Felliti, and CDC)
Increased presence of adverse experience leads to increased risk of:

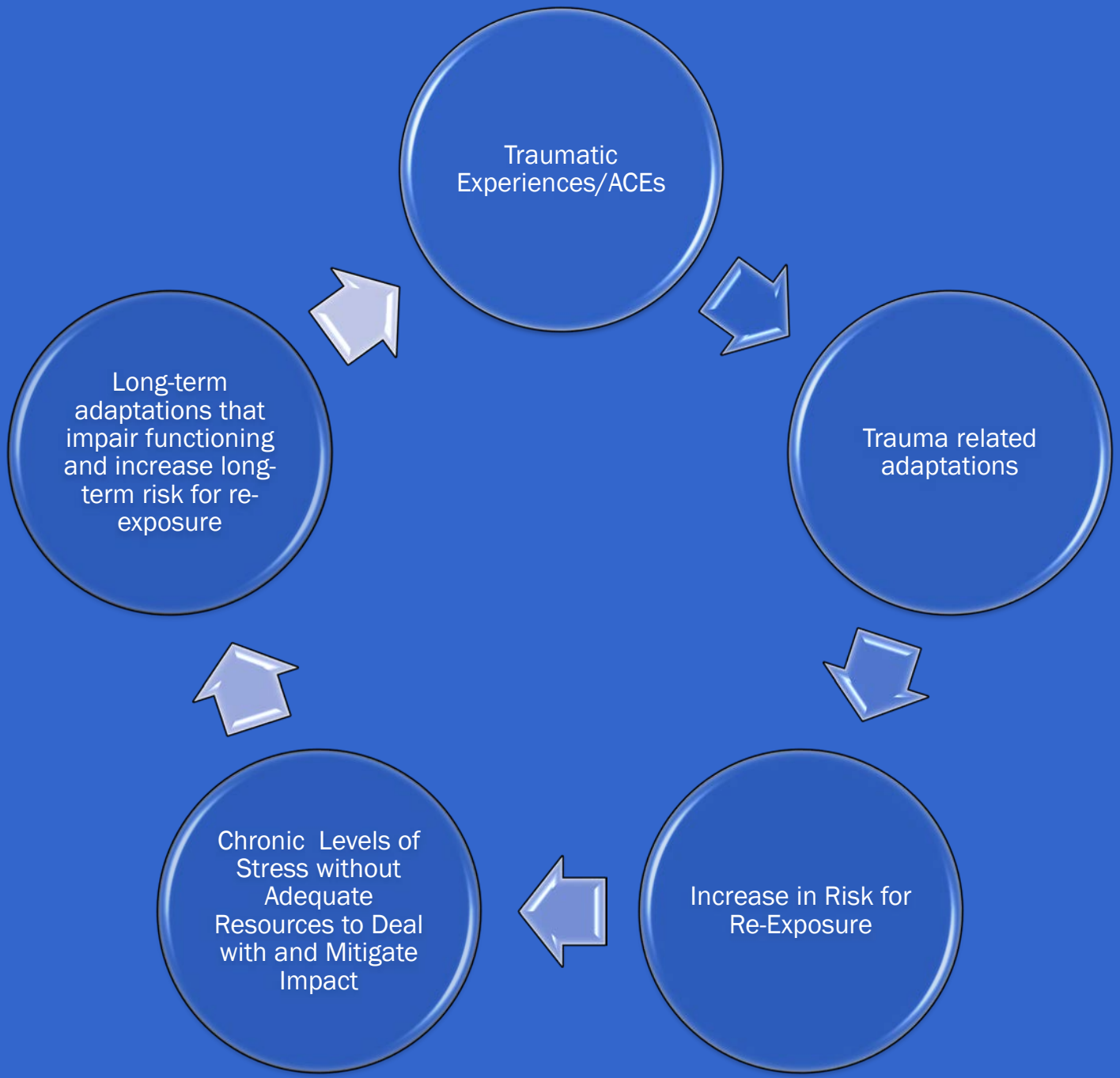
- Depression
- Drug addiction
- Alcohol use/abuse
- Adult sexual assault
- Adult domestic violence (perpetrator and victim)
- Teen pregnancy and teen paternity
- Suicide
- Obesity
- Cigarette use
- General health problems

Adverse Childhood Experiences Study (ACES)



Mechanisms by which Adverse Childhood Experiences Influence health and well-being through the lifespan

Felitti et al. (1998) Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults, ***American Journal of Preventative Medicine***


Traumatic Experiences/ACEs
Trauma related adaptations
Increase in Risk for Re-Exposure
Chronic Levels of Stress without Adequate Resources to Deal with and Mitigate Impact
Long-term adaptations that impair functioning and increase long-term risk for re-exposure

The Co-Occurring Nature of Trauma

"Individuals with a trauma history rarely experience only a single traumatic event, but rather are likely to have experienced several episodes of traumatic exposure."

Cloitre et al., 2009

(Retrospective studies, e.g., Kessler, 2000; Stewart et al., 2008; Coid et al., 2001; Dong et al., 2004)

Finkelhor et al. (2009)

Nationally Representative Sample (n=4549)

Nearly 40% had experienced two or more types of direct victimization in the past year.

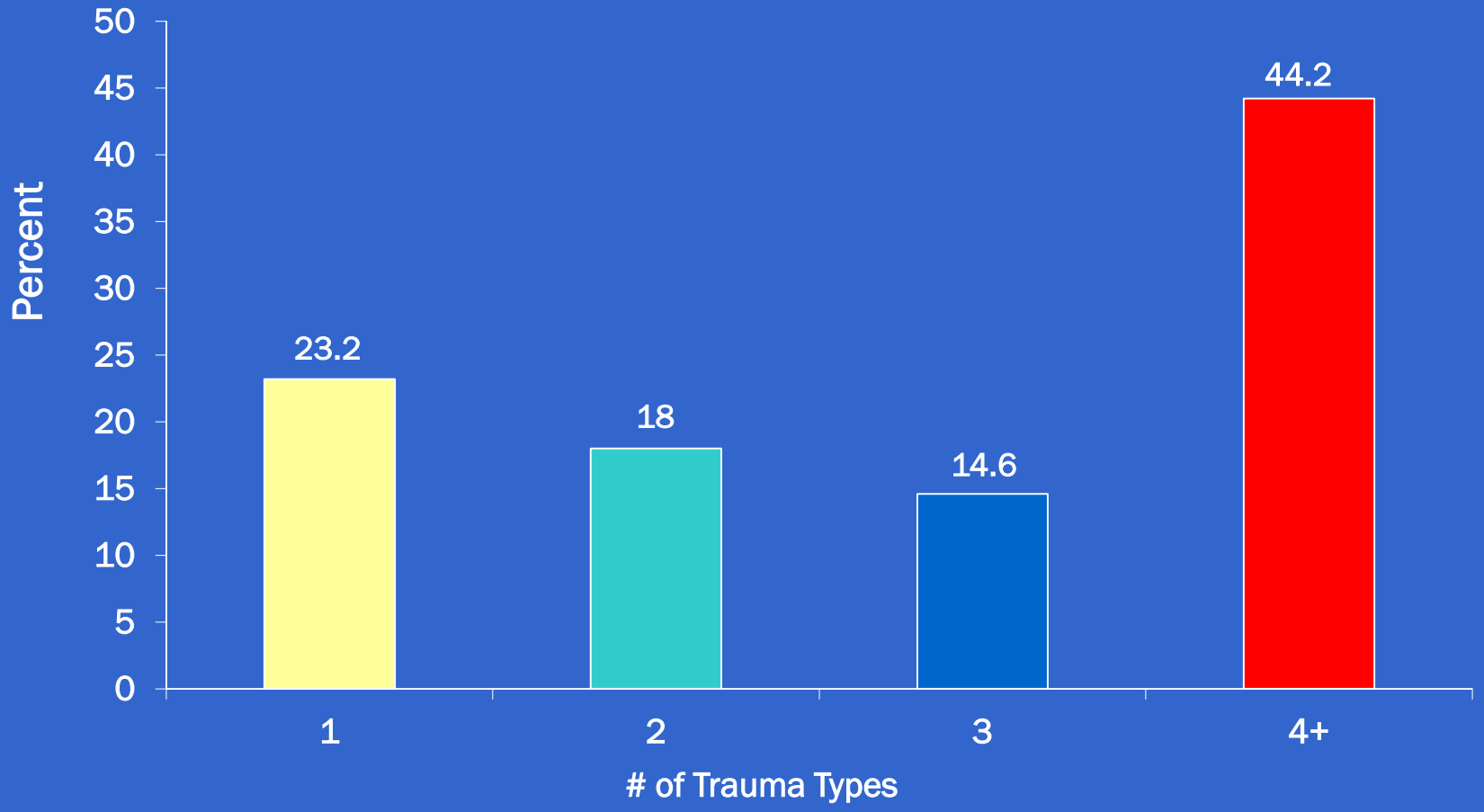
NCTSN Core Data Set (2012)

Children Served in the National Child Traumatic Stress Network (n=11,138)

Fewer than 24% had experienced only one type of trauma or ACE.

Over 40% had experienced 4 or more.

Percentage of Children in the NCTSN Core Data Set Experiencing Cumulative Traumas



Chicago Child Trauma Center Traumatic Stressors Experienced by Children Served in FY12

Sexual Abuse	55%
Witnessed Domestic Violence	48%
Physical Abuse	44%
Witnessed Physical or Sexual Abuse	36%
Traumatic Loss (e.g., by homicide or suicide)	26%
Witnessed Community Violence	21%
Medical Trauma (e.g., Burns, MVA, Dog Attack)	15%
Victim of Extrafamilial Violent Crime	8%
Witnessed Homicide	6%
Fire	5%

Other trauma types include school violence, abduction, torture, witnessing serious injury, trafficking

Mean # of Types of Traumatic Stress = 2.88 73% Exposed to 2 or More

Trauma Exposure

91% experienced at least one form of interpersonal trauma.

74% experienced at least one form of family violence.

69% experienced at least one form of ongoing traumatic stress.

86% of children exposed to DV were also exposed to Physical and/or Sexual Abuse.

Other Adverse Experiences (Children Served in FY12)

Impaired Caregiver (e.g., mentally ill, substance abusing)	63%
Placement in Foster Care	55%
Neglect	41%
Unresolved Trauma History in Caregiver	41%
Emotional Abuse	30%
Death of Significant Other (not TL)	26%
Incarcerated Family Member	26%
Exposure to Prostitution or other Developmentally Inappropriate Sexual Behavior in Home	24%
Exposure to Drug Use or Criminal Activity in Home	21%
Substitute Care (not foster care)	18%
Homelessness	12%

Mean # of Types of Other ACES = 3.6 74% Experienced 2 or More

Mean Combined Total Types of Traumatic Stressors + Other Adverse Childhood Experiences =

6.51

74% Experienced 4 or More

Range = 1 – 16

Fewer than 10% experienced only 1 type.

The Attachment Behavioral System

- Attachment: an evolved behavioral system that functions to promote the protection and safety of the attached person

- Attachment system is activated strongly by internal and external stressors or threats.

- It is through healthy attachment (i.e., a behavioral system that effectively protects and comforts the infant or child) that a child develops the capacity for emotional and behavioral self-regulation, as well as a coherent self.

Attachment

Internal Working Models: complementary representations of the self and the attachment figure

These models reflect the child's appraisal of, and confidence in, the self as acceptable and worthy of care and protection, and the attachment figure's desire, ability, and availability to provide protection and care. – Solomon & George, 1999

Dissociation

- "...a complex psychophysiological process...that produces an alteration in the person's consciousness. During this process, thoughts, feelings and experiences are not integrated into the individual's awareness in the normal way." – Putnam, 1985

- "a mechanism by which some of the systems of experience and some of the somatic apparatuses are disintegrated from the rest of the personality"

  - Sullivan, 1929

The Trauma Response

Amygdala

Interpretation of emotional significance

Sends information to the hippocampus to be processed and stored

When firing rapidly, inhibits hippocampal functioning

Information is not integrated into preexisting schemes

The Trauma Response

- Psychobiological Theory
  - Traumatic memory is not processed or interpreted
  - Traumatic memory is stored in visual or somatosensory (including affective) impressions

Some Basic Assumptions About Psychological Traumatization

Traumatic experiences are those which overwhelm an individual's capacity to integrate experience in the normal way. (e.g., Putnam, 1985)

Following exposure to trauma, if integration does not occur, traumatic experience(s) are split off and an individual alternates between functioning as if the trauma is still occurring and functioning as if the trauma never occurred. (e.g., Nijenhuis et al., 2004)

Although traumatic memories and associations remain inaccessible to consciousness much of the time, they have the power to shape an individual's daily functioning and behavior. (e.g., Allen, 1993)

Posttraumatic Stress Disorder

- Re-experiencing
- Numbing
- Hypervigilance
- Avoidance

Limitations of PTSD Diagnosis for Children

- Conceptualized from an adult perspective
- Identified as diagnosis via Vietnam vets and adult rape victims
- Focuses on single event traumas
- Fails to recognize chronic/multiple/on-going traumas
- Is not developmentally sensitive and does not reflect the impact of trauma on brain development
- Most traumatized children do not meet full diagnostic criteria

Children's Posttraumatic Reactions: Risk for Misdiagnosis and Mislabeling

Children presenting with posttraumatic symptoms are at risk of being misdiagnosed with a variety of disorders and functional difficulties particularly when a comprehensive assessment for complex trauma issues is not conducted

- ✓ ADHD
- ✓ Depressive Disorders
- ✓ Oppositional Defiant Disorder
- ✓ Conduct Disorder
- ✓ Reactive Attachment Disorder
- ✓ Psychotic Disorders
- ✓ Specific Phobias
- ✓ Learning/ academic difficulties
- ✓ Juvenile Delinquency

Beyond Posttraumatic Stress Disorder

Complex Trauma, Type II Trauma, Betrayal Trauma, Developmentally Adverse Interpersonal Trauma and Maltreatment, ACEs, Extreme Stress Not Otherwise Specified....

have profound effects on development, functioning, personality, and the capacity to live, love, and be loved.

These effects are not accounted for in our current diagnostic classification system, nor are they addressed in standard simple PTSD treatment approaches.

Key Developmental Capacities Affected by Complex Trauma

Ability to modulate, tolerate, or recover from extreme affect states

Regulation of bodily functions

Capacity to know emotions or bodily states

Capacity to describe emotions or bodily states

Capacity to perceive threat, including reading of safety and danger cues

Capacity for self-protection

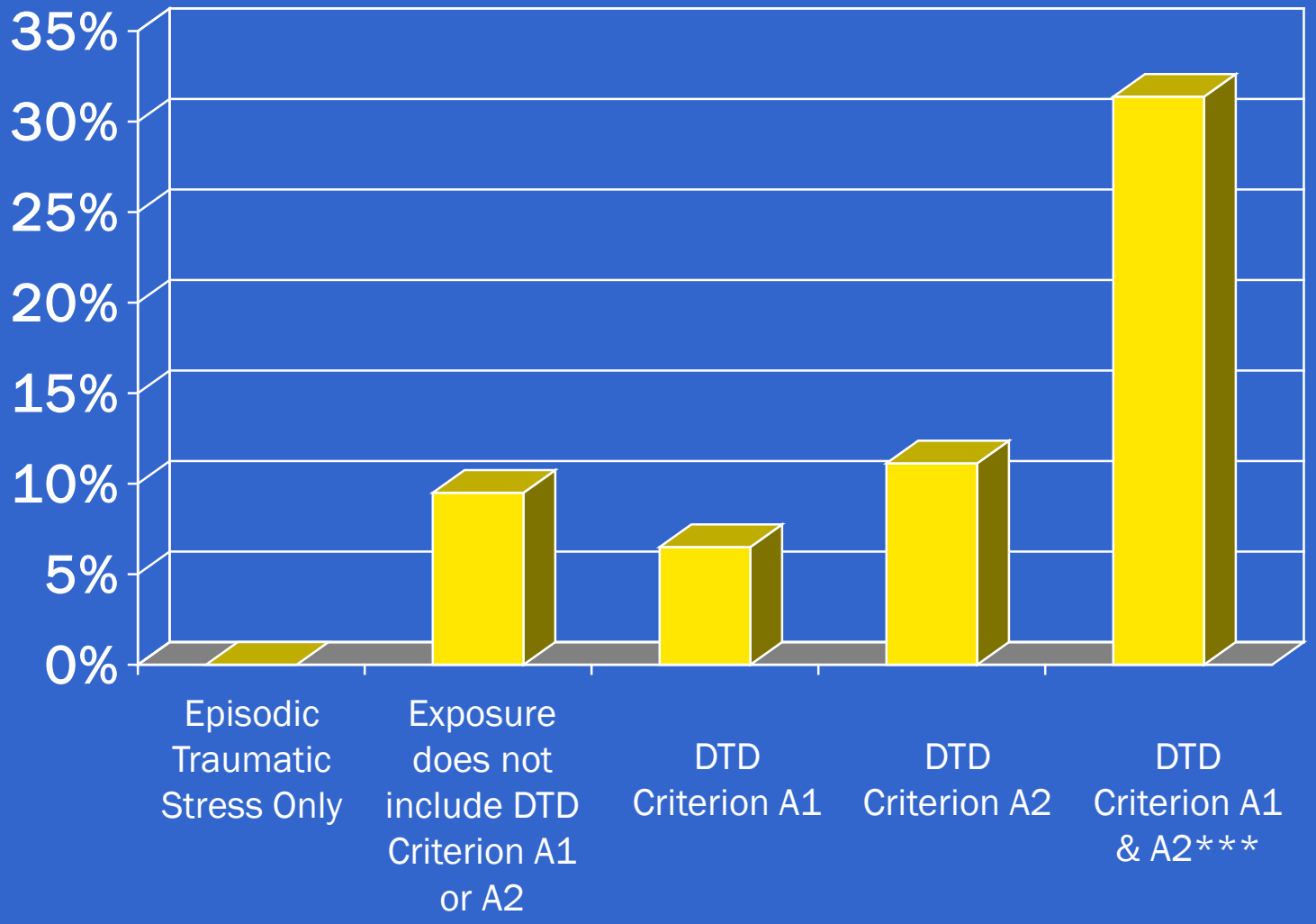
Capacity for self-soothing

Ability to initiate or sustain goal-directed behavior

Coherent self, Identity

Capacity to regulate empathic arousal

% Meeting DTD Symptom Criteria by Criterion A Exposure



Stolbach et al., 2013

Histories of Trauma Exposure in Former Child Soldiers in Uganda

Abduction	99%
Exposure to Armed Combat	92%
Physical Assault	90%
Witnessed Killing	88%
Community Violence	56%
Rape by Rebels	26%
Physical Abuse	26%
Sexual Assault in Community	24%

Klasen et al., 2013

PTSD, MDD & DTD in Former Child Soldiers in Uganda

Posttraumatic Stress Disorder	33%
Major Depressive Disorder	36%
Developmental Trauma Disorder	78%
PTSD Only	1%
MDD Only	3%
DTD Only	32%
Two Diagnoses	30%
All Three	17%
None	17%

Klasen et al., 2013

Who is a Child Soldier?

A child soldier is any person under 18 years of age who is part of any kind of regular or irregular armed force or armed group in any capacity, including but not limited to cooks, porters, messengers and anyone accompanying such groups, other than family members. The definition includes girls recruited for sexual purposes and for forced marriage. It does not, therefore, only refer to a child who is carrying or has carried arms.

Cape Town Principles and Best Practices on the Recruitment of Children into the Armed Forces and on Demobilization and Social Reintegration of Child Soldiers in Africa (Cape Town, 27-30 April 1997).

"...U.S. researchers do not have to travel to remote parts of the globe to encounter child soldiers—we can find them in our own backyard, among the many youth who are involved in street gangs. Clearly, there are differences that must be acknowledged: U.S. youth are rarely forcibly abducted into gangs as have been the majority of youth described in the [literature], and even our most violent inner-city environments do not match the levels of social, cultural, and physical disarray and degradation that characterize active war zones. However, there are parallels that are disconcerting, including the fact that gang-involved youth are compelled to witness, endure, and perpetrate acts of violence against others that leave them with the scars of trauma exposure....Just as with child soldiers in Uganda, Sierra Leone, and Colombia, emerging research suggests that gang-involved youth in the United States who perpetrate against others evidence the most severe symptoms of PTSD and the most maladaptive outcomes."

Kerig & Wainryb, 2013

Worst Forms of Child Labour

For the purposes of this Convention, the term the worst forms of child labour comprises:

(a) all forms of slavery or practices similar to slavery, such as the sale and trafficking of children, debt bondage and serfdom and forced or compulsory labour, including forced or compulsory recruitment of children for use in armed conflict;

(b) the use, procuring or offering of a child for prostitution, for the production of pornography or for pornographic performances;

(c) the use, procuring or offering of a child for illicit activities, in particular for the production and trafficking of drugs as defined in the relevant international treaties;

(d) work which, by its nature or the circumstances in which it is carried out, is likely to harm the health, safety or morals of children.

- International Labor Organization (ILO) Convention Concerning the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour art. 3, June 17, 1999, S. Treaty Doc. No. 106-5 (ILO Convention 182)

"The types of services performed by juvenile gang members, from selling and transporting drugs to engaging in crimes against persons and weapons crimes, fall under at least one of the enumerated 'worst forms of child labor,' particularly those at (c) and (d)."

Rizen, 2015, p. 167

Two 17-year-old girls were hurt during a gang-related car crash early Saturday morning in the Logan Square neighborhood on the Northwest Side, police said.

Around 1:45 a.m., several people in a Honda Accord and a Toyota were chasing each other, flashing gang signs, when both cars stopped.

Two 17-year-old girls came out of the Honda and ran behind it. The driver of the Toyota then put his car in reverse and struck the Honda, which hit one of the girls and pinned the other, police said.

Both girls were taken to Advocate Illinois Masonic Medical Center. The girl who was pinned was stabilized, and the other girl had minor injuries, police said.

The two girls are documented gang members, police said.

A 15-year-old boy was shot in Englewood, authorities said. Around 12:50 a.m., the boy was in a parked car when someone opened fire, striking him in his arm, Estrada said. He was taken to Holy Cross Hospital where he is in stable condition.

The boy was a documented gang member, and the shooting may have been gang-related, Estrada said.

The Power of a Lens
Criminal or Maltreated Child or Child Soldier

U.S. incarcerates more than twice as many youth per 100,000 than next highest youth incarcerator.

Many of these youth are classified by statute as adults.

Youth of color are much more likely than others to be incarcerated. In Cook County, Illinois, African American youth are 46 times more likely than White youth to be incarcerated.

Cook County Circuit Court, 2012

Urban Violence in Historical & Societal Context

Dr. Paul Farmer: “Structural violence is one way of describing social arrangements that put individuals and populations in harm’s way… The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people.”

Farmer, Nizeye, Stulac, & Keshavjee, 2006

“Neither culture nor pure individual will is at fault; rather, historically given (and often economically driven) processes and forces conspire to constrain individual agency. Structural violence is visited upon all those whose social status denies them access to the fruits of scientific and social progress.”

Farmer, 2001

The Context

See Boyd-Franklin, 2003; Franklin et al., 2006

The Stress of Being Black in America

- Chronic Environmental Stress
  - Unemployment
  - Poverty
  - Race-based stressors
  - Microaggressions
  - Invisibility Syndrome
  - Role Strain
  - Disproportionate Incarceration Rates
  - Health Disparities
  - Education Disparities
  - Residential Segregation

See Boyd-Franklin, 2003; Franklin et al., 2006

Child Trauma, "Race" and Urban Poverty

Urban Black and Brown families face a unique set of adversities and stressors. The massive historical traumas of attempted genocide and slavery have never been addressed, yet create the context in which present traumas occur and are dealt with. Those of us working with children and families whose daily existence is shaped by the legacy of slavery and racial injustice cannot optimally intervene if we fail to understand and address the effects of the trauma of the past.

Stolbach & Parks, 2007

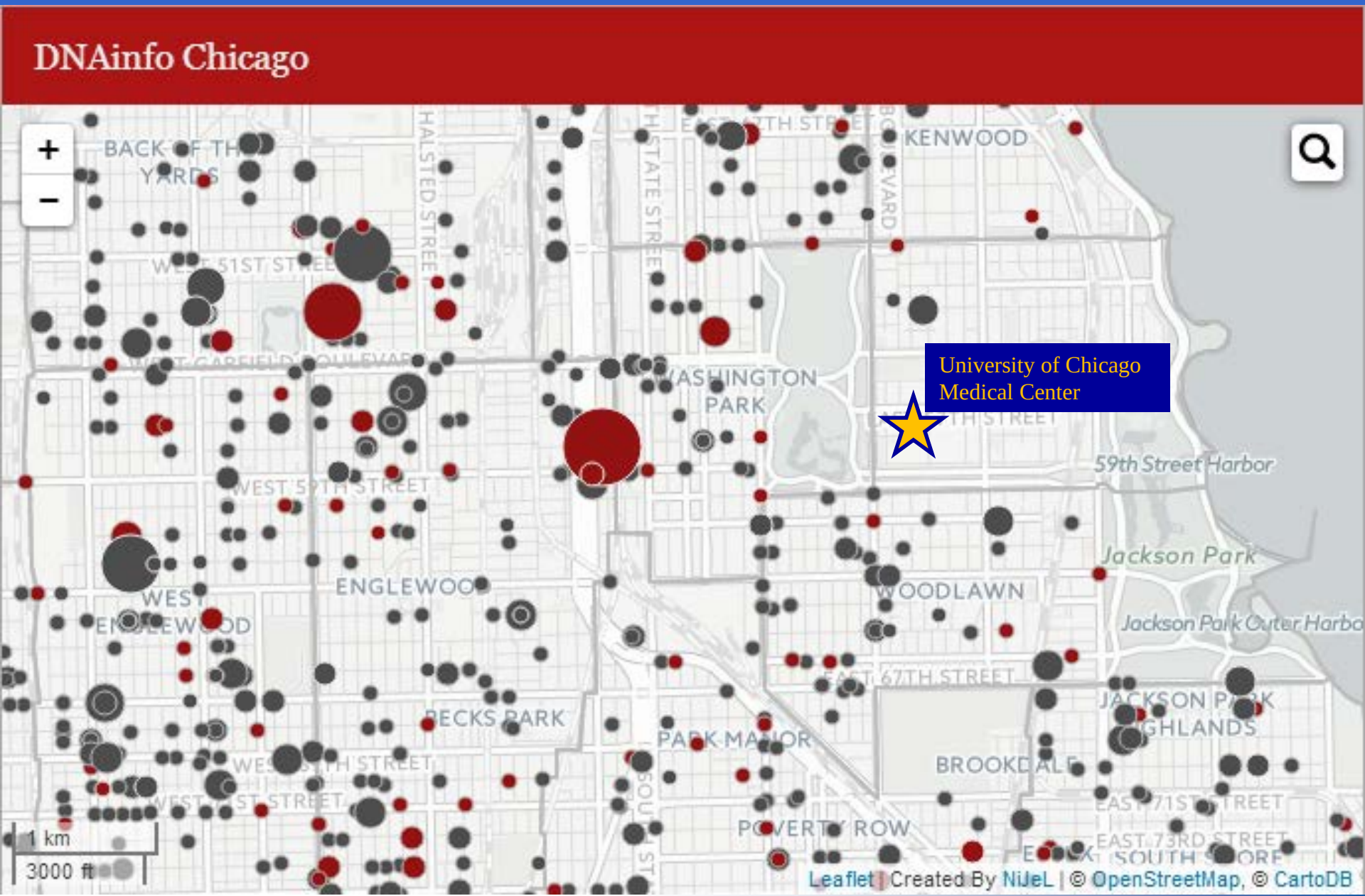
Societal Traumatization and the Legacy of Imperialism, Attempted Genocide, & Slavery

Just as in cases of individual traumatization, avoidance of acknowledging and addressing the traumatic past makes it impossible for integration to occur.

As long as historical trauma remains taboo, the racial divisions and disparities that pervade every aspect of American life will persist.

Stolbach & Parks, 2007

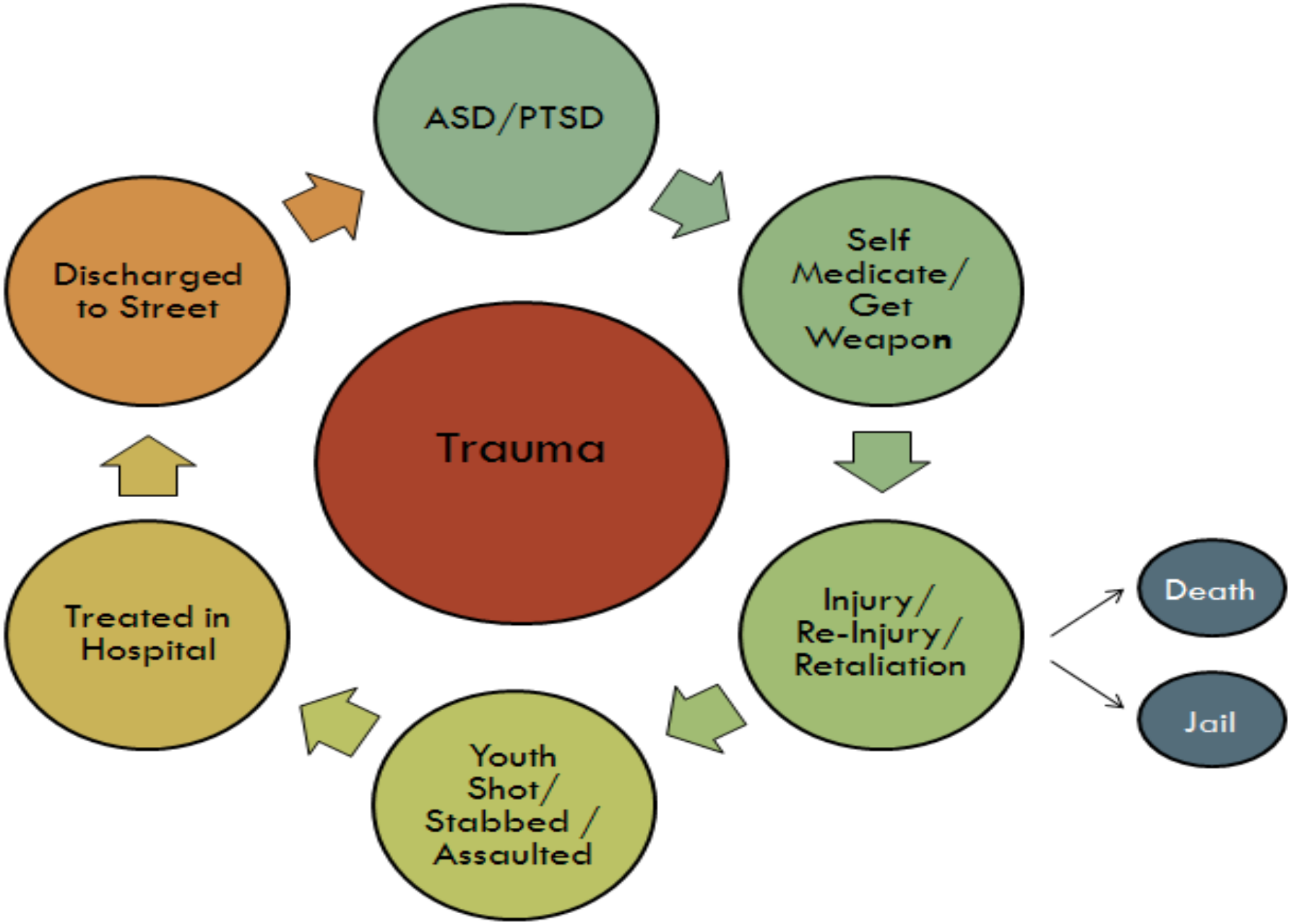
2015 Shootings in Chicago



“[A] high level of violence in their communities makes young men feel physically, psychologically, and socially unsafe. Physically, young men who have been shot, stabbed or attacked fear that unless they arm themselves, someone else might attempt to harm them as they have been injured before. Psychologically, they are left with the hypervigilance and disruption that come from trauma. Socially, they have often been raised in communities where there is a shared idea that if you fail to defend yourself when challenged, you become a “sucker,” which will lead other people, who now believe you are weak, to take advantage of you….Sadly, because of their social position and the legacy of violence, racism, and poverty into which they have been born, they have become, for many of us, strange icons of fear. Each time a shooting or a stabbing or an assault is reported in the news, the details obscure a young man with a story, a young man with real blood running through his veins.”

John Rich, MD, Wrong Place, Wrong Time, pp. xiv-xv

"Cycle of Violence"



“Gang-Involved” Youth Self-Reported Trauma Exposure

n = 8

Physical Abuse	100%
Witnessed Physical Abuse	100%
Witnessed Domestic Violence	100%
Witnessed Community Violence	100%
Witnessed School Violence	100%
Witnessed Homicide(s)	75%
Loss Through Violent Death	75%
Witnessed Sexual Victimization	62.5%
Motor Vehicle Accident	50%
Victim of Extrafamilial Violent Crime	50%
Dog Attack	37.5%
Burns	37.5%

Other trauma types include fire, natural disaster, torture

Bocanegra & Stolbach, 2012

Youth Self-Reported Trauma Exposure

100% experienced both family violence and community violence.

100% experienced at least one form of ongoing traumatic stress.

Average age of first trauma exposure = 6 years, 1 month

Mean # Types of Trauma Experienced = 10

Range = 7 - 13

Bocanegra & Stolbach, 2012

Youth Other Adverse Experiences

Impaired Caregiver	75%
Exposure to Drug Use or Criminal Activity in Home	75%
Exposure to Prostitution or other Developmentally Inappropriate Sexual Behavior in Home	37.5%
Substitute Care	25%

Other ACEs include incarcerated significant other, homelessness, neglect

Mean # Types of Adverse Experiences = 2.75

Range # Types of Adverse Experiences = 0 – 5

Bocanegra & Stolbach, 2012

Youth
Mean Combined Total Types
of Traumatic Stressors +
Other Adverse Childhood Experiences =

12.75

Range = 7 - 18

Bocanegra & Stolbach, 2012

Trauma and Adverse Life Events of Incarcerated Girls (n=10)

Trauma

100% had at least one form of family violence.

80% had at least one form of ongoing traumatic stress.

80% had at least one form of traumatic stress prior to age 6, including 30% who had exposure to violence from birth.

Mean = 8.5; Range = 3 - 15

Adverse Life Events

70% had impaired caregiver, incarcerated significant other, and exposure to drug use/criminal activity in home

60% had neglect and death of significant other

Mean = 4.8; Range = 2 – 8

Mean combined total types of traumatic stressors + other adverse childhood experiences = 13.3

Complex Trauma and Reactive vs. Instrumental Aggression

Reactive aggression entails impulsivity, anger, and intolerance for perceived provocation whereas instrumental aggression is motivated by material or social gain (Crapanzano et al., 2010).

In a study of juveniles convicted of committing violent crimes, Silvern & Griese (2012) found that:

Multiple maltreatment positively predicted reactive aggression. The significant relationship between multiple maltreatment and reactive aggression was fully mediated by dissociative symptoms and partially mediated by PTSD symptoms.

Changing Voices Participants Self-Reported Trauma Exposure

n = 9, age 17-26

Witnessed Community Violence	100%
Witnessed School Violence	89%
Loss Through Violent Death	89%
Victim of Extrafamilial Violent Crime	67%
Witnessed Physical Abuse	56%
Fire	56%
Medical Trauma	56%
Witnessed Domestic Violence	44%
Motor Vehicle Accident	44%
Witnessed Homicides (range = 2-5)	33%
Sexual Victimization	33%
Physical Abuse	22%

Other trauma types include stalking, earthquake

Changing Voices Self-Reported Trauma Exposure

Average age of first trauma exposure =
4 years, 4 months
Range = 0 - 13

100% experienced at least one form of ongoing traumatic stress with 5 reporting at least 1 stressor that was present for “my whole life.”

Mean # Types of Trauma Experienced Prior to Age 18 =

6.78

Range = 4 – 10

Changing Voices
Self-Reported Other Adverse Experiences

Incarceration	100%
Loss/Bereavement	78%
Substitute or Foster Care	67%
Incarcerated Family Member	67%
Exposure to Drug Use or Criminal Activity in Home	67%
Impaired Caregiver	56%
Homelessness	56%
Unresolved Trauma in Caregiver	33%
Neglect	22%
Exposure to Prostitution or other Developmentally Inappropriate Sexual Behavior in Home	11%

Mean # Types of Adverse Experiences = 4.67 by age 18; 5.67 by age 23

Range # Types of Adverse Experiences = 2 – 9

Mean Combined Total Types
of Traumatic Stressors +
Other Adverse Childhood Experiences
Prior to Age 23 =

12.89

Range = 5 - 18

Changing Voices Self-Reported Gang Affiliation, Violence, and Weapons Use

n = 9

44% reported having inflicted a violent injury on someone.
Average exposure for these individuals = 16

44% reported having carried a gun for protection.
Average exposure for these individuals = 16.75

67% reported having a family member affiliated with a gang/street organization.

44% reported having been affiliated with a gang/street organization.

Ages of first affiliation for these individuals = 9, 12, 14, 16

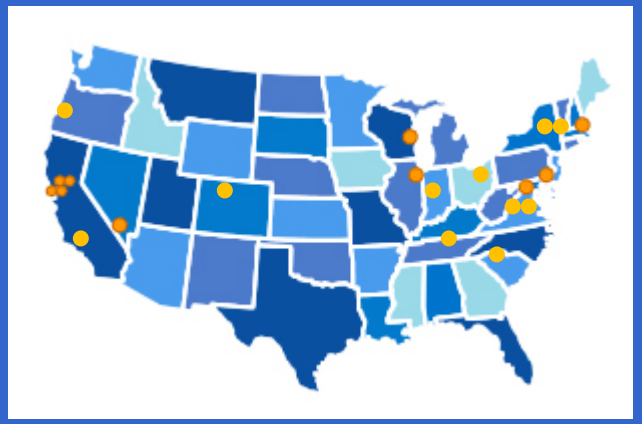
The only way to counter the effects of structural (systemic) violence is for existing systems to actively work to change and to work collaboratively across systems and disciplines to serve the best interests of their clients.

"The way we deal with trauma is together. Recovery only occurs through relationship – collaboration, cooperation, and communication. Our goal is to create a community where individuals and individual systems work ***together*** to ***support*** each other to promote ***recovery*** of children, adolescents, families, and communities."

- St. Thomas/St. John Trauma-Informed Care Learning Community
  NCTSN Complex Trauma Treatment Network

National Network of Hospital-based Violence Intervention Programs

- Violence is a preventable health-care issue
- Trauma centers and emergency rooms have a golden moment of opportunity to engage with a victim of violence and stop the cycle of violence



Violent Injury is a Reoccurring Disease

Cunningham et al., 2015

Patients 14-24 presenting to Urban ED (Flint, MI)

24-Month Reinjury Rate

Assault-Related Injury Patients	36.7%
Non-AI Patients	22.4%

Chong et al., 2015

Patients 12-24 presenting to Urban ED (East Bay)

Risk Factor	OR
Male	2.24
Black/African American	2.14
Firearm Injury	2.28
Public Insurance	1.56
Low SES Neighborhood	1.48

Hospital-Based Violence Intervention Programs are Cost-Effective

Chong et al., 2015

Patients 12-20 presenting to Urban ED (East Bay) with GSW

Costs for patients receiving HVIP Services and Standard Risk Reduction were equivalent ($3,574 vs. $3,515)

1-Year Injury Recidivism Rates for HVIP = 2.5% vs. 4% SRR

Average Hospital Costs after Recidivism

HVIP $6,513 SRR $18,722

Purtle et al., 2015

Cost-Benefit Analysis Simulation

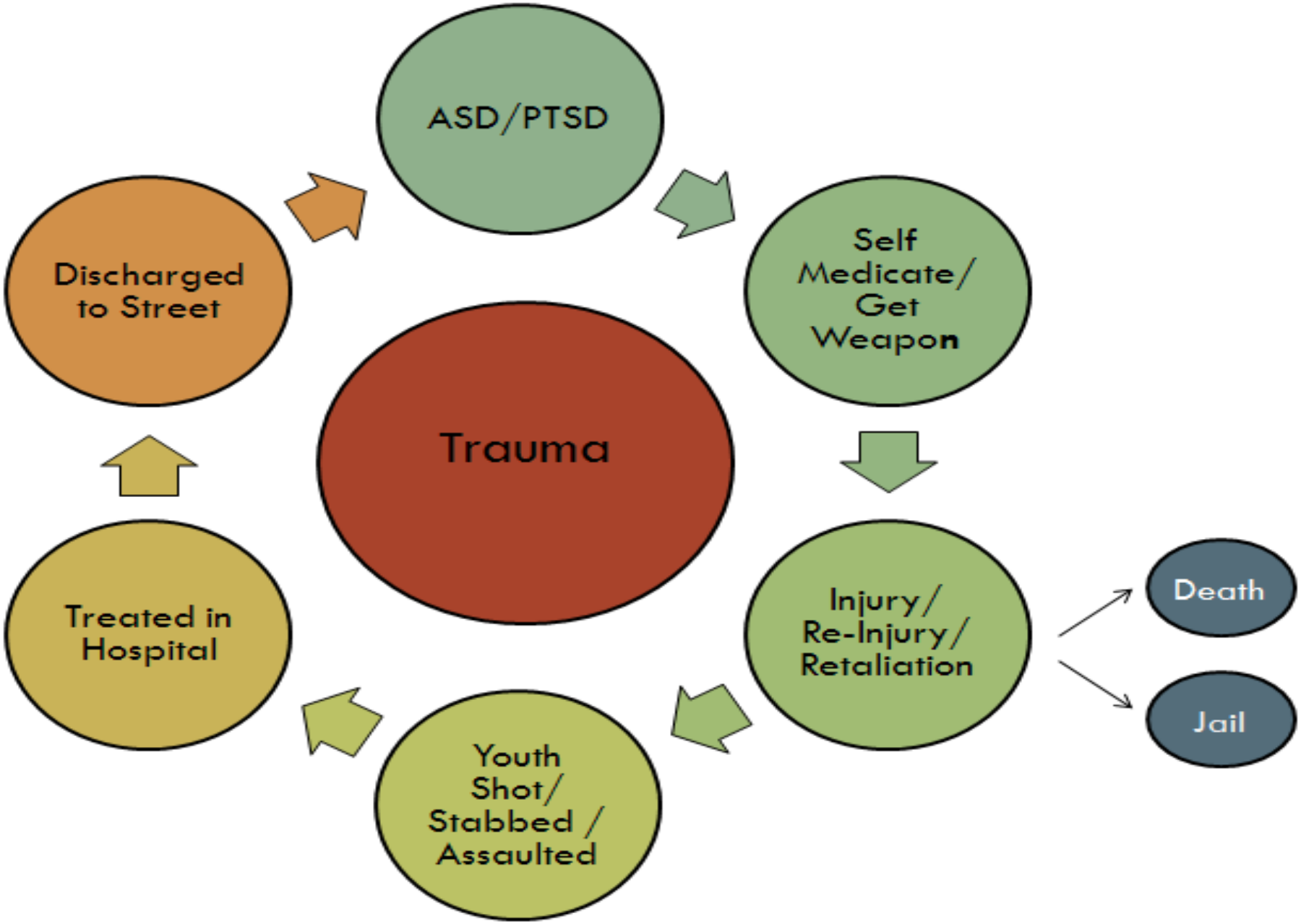
Per-Patient Cost = $3,889

At Base Effect of 25% Cost Savings ranged from

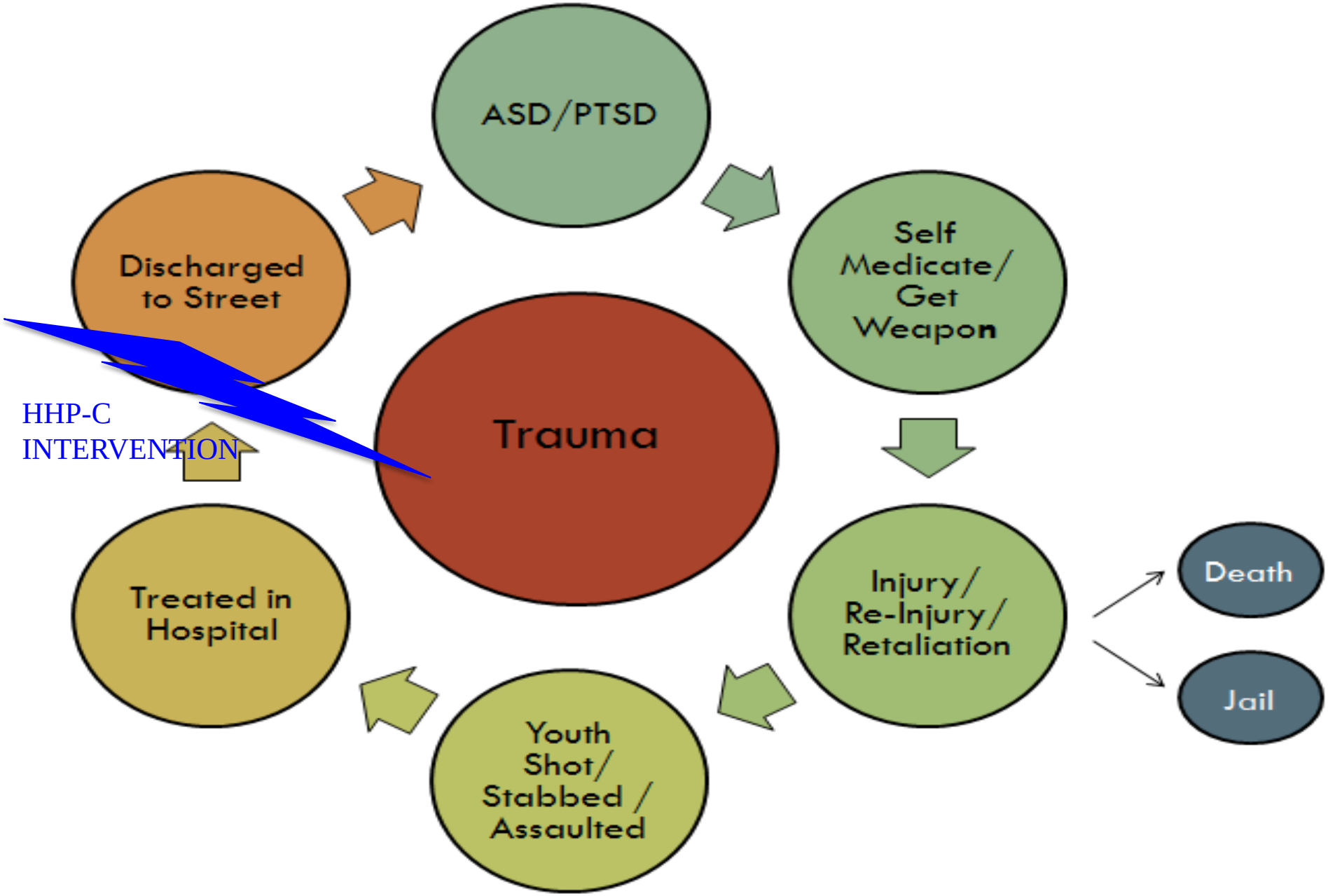
$82,765 (reinjury healthcare costs only) to

$4,055,873 (reinjury healthcare costs + perpetration victim healthcare costs + perpetration criminal justice costs + lost productivity costs)

"Cycle of Violence"



"Cycle of Violence"



Healing Hurt People is a Trauma-Informed Hospital-Based Violence Intervention model developed at Drexel University's Center for Nonviolence and Social Justice under the direction of John Rich, MD, Sandy Bloom, MD, and Ted Corbin, MD

healing hurt people chicago

Intensive case management, starting in the hospital and continuing after discharge.

- Trauma Psychoeducation (S.E.L.F. Groups)
- Victims Compensation
- School (Homebound, Enrollment, GED)
- Ongoing trauma-focused counseling
- Help getting to medical appointments
- Arrange durable medical equipment
- Safety planning
- Job training, housing/relocation needs

PROGRAM GOALS

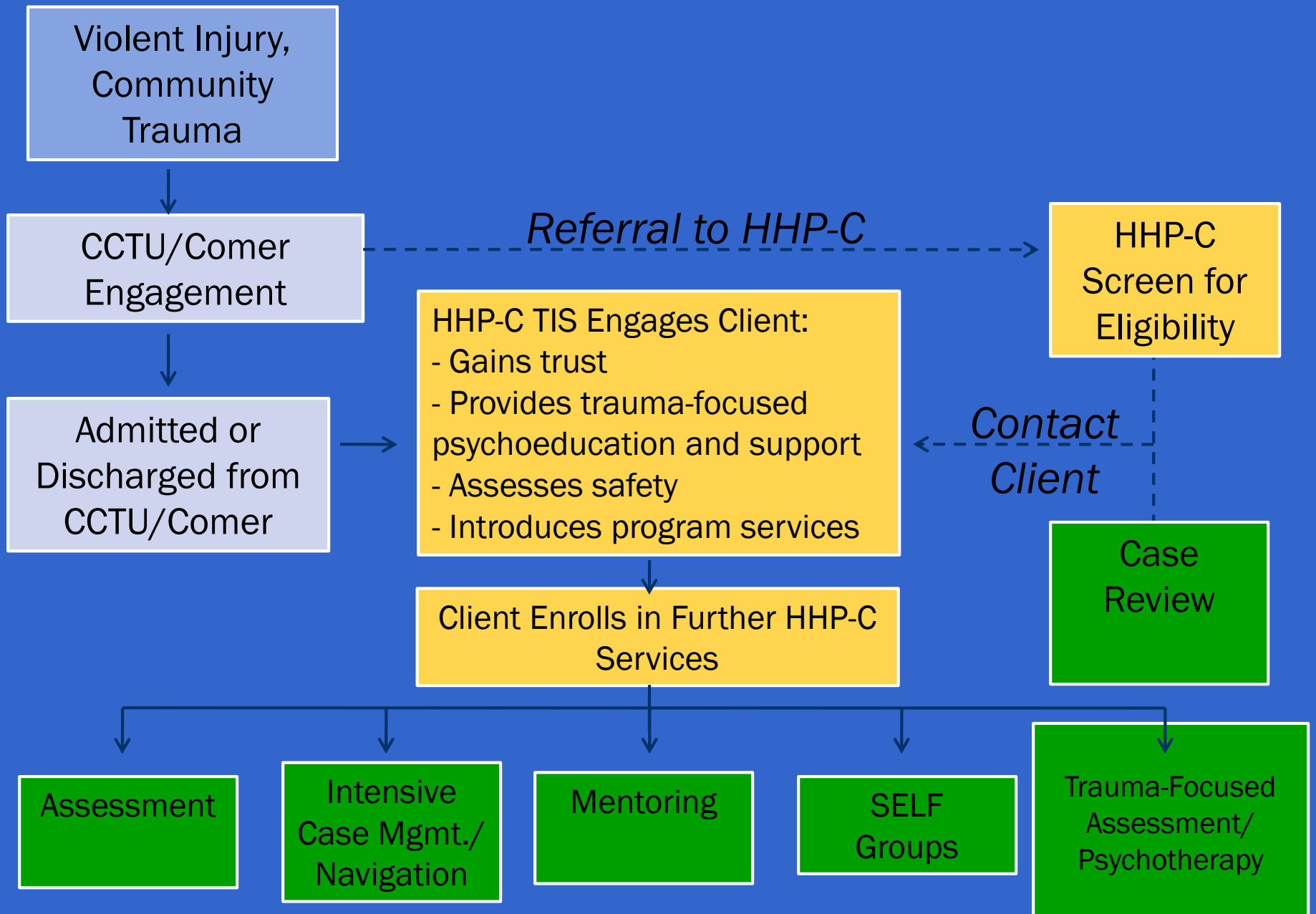
Healing Hurt People-Chicago has three primary goals.

1. Provide trauma-informed care in order to promote recovery and reduce re-injury, retaliation and arrests among violently injured youth.

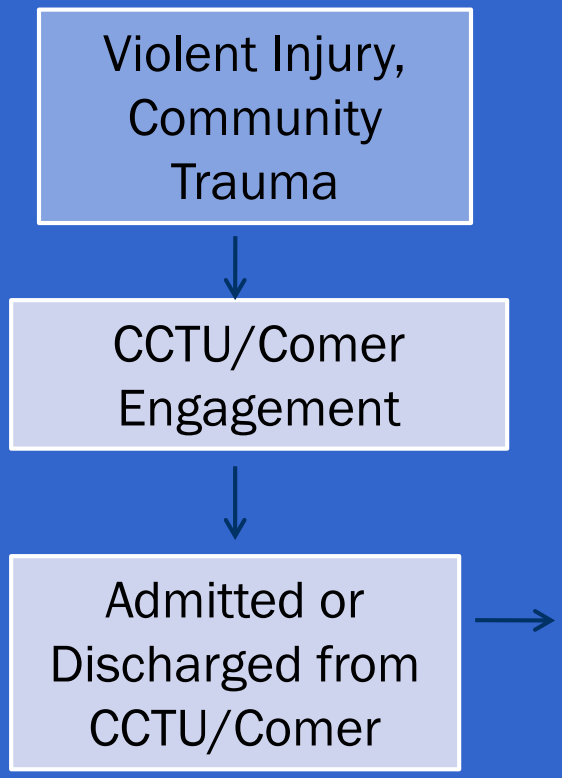
2. Increase patients' capacity to thrive–emotionally, physically, socially—building a strong future for themselves and their families.

3. Integrate trauma-informed practice into philosophy of care and core competencies, laying the groundwork for integration into the Cook County Health and Hospitals System and University of Chicago Medicine.

Healing Hurt People - Chicago Flow Chart



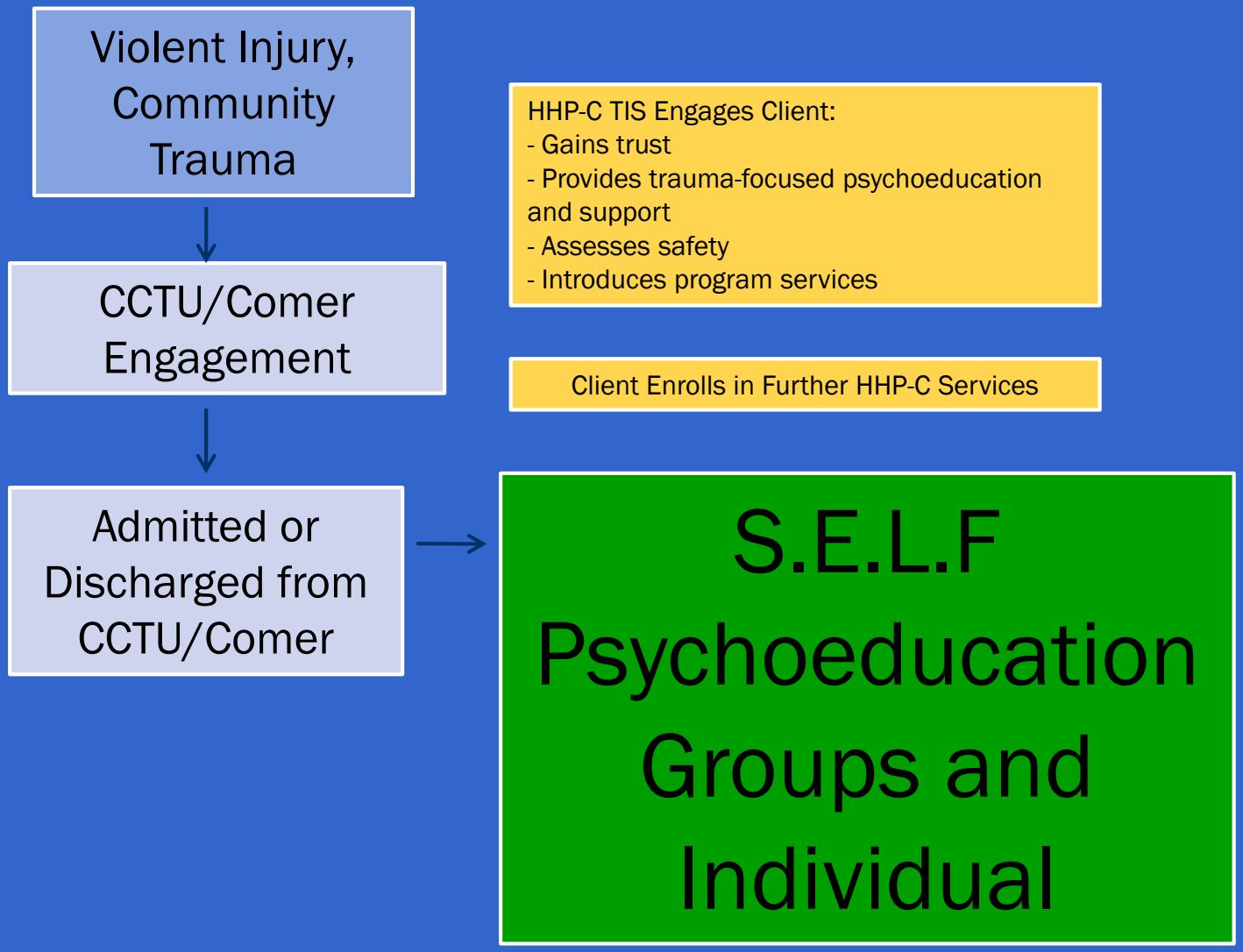
Healing Hurt People - Chicago Flow Chart



HHP-C TIS Engages Client:

- Gains trust
- *Provides trauma-focused psychoeducation and support*
- Assesses safety
- Introduces program services

Healing Hurt People - Chicago Flow Chart



The S.E.L.F. Psychoeducation Model

Joseph Foderaro, MSW, LCSW; Ruth Ann Ryan, APRN, BC; Sandra L. Bloom, MD

SELF Groups focus on teaching/mentoring participants regarding:

Safety - Planning for physical and emotional safety, including avoiding re-injury and retaliation;

Emotions - Managing the strong emotions that come with violent injury and a lifetime of trauma and adverse experiences;

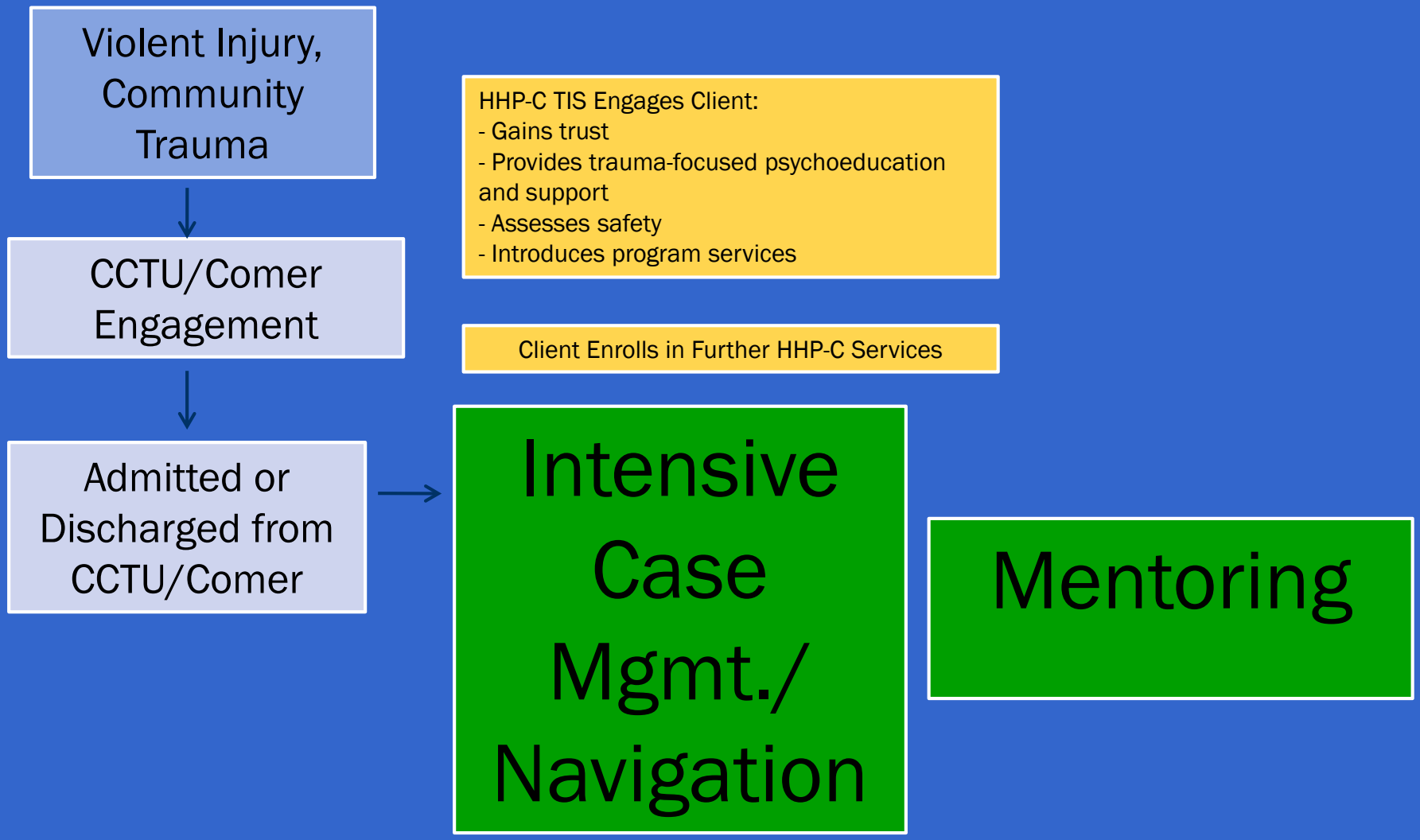
Loss and/or Letting Go - Dealing with losses resulting from injury along with 'letting go' that is necessary for change;

Future - Promoting healing by reconstructing a vision for the future and creating supportive relationships that bring participants closer to it.

The S.E.L.F. Psychoeducation Model

"When I first came here, I didn't really know what it was gonna come out to. I thought it was gonna be like us just sitting in circles, talking about what happened to us. **But I didn't think people really cared about African American boys, you know, young, like we just get shot, go to the hospital, and go home.** And then I came here and I seen something different, learned something new. I heard everybody's stories.... When I got shot I didn't wanna do nothing no more. I used to spend all my time in gyms, working out, just doing fun outside. Y'all made me look different. Y'all made me wanna do everything again, be able to go outside, kick it with people, family. **I guess you could say I got my life back."**

Healing Hurt People - Chicago Flow Chart



Healing Hurt People - Chicago
ORGANIZATIONAL CHART SEPT. 2016

John H. Stroger, Jr. Hospital of Cook County Dept. of Trauma

The Rev. Carol S. Reese, LCSW
Site P.I./Program Director
Violence Prevention Coordinator
Chaplain

University of Chicago Comer Children's Hospital

Brad Stolbach, PhD
P.I./Clinical Director

Drexel University Center for Non-Violence and Social Justice

John Rich, MD, MPH
Theodore Corbin, MD, MPP
Sandra Bloom, MD
Rachel Compton, LCSW
Linda Rich, MA
Ruth Ann Ryan, APRN, BC
Joseph Foderaro, MSW, LCSW

Ongoing Consultation, Training, and Evaluation of Program Fidelity and Outcomes

Andrew Wheeler, AM
Patient/Family Support Coordinator
8/2013-Present

Stroger Hospital Social Work Interns

Trauma Intervention Specialists

Spring 2015-<u>Present</u>
Artesha Williams
Cordelia Loots-Gollin
Leigh Schuster
Hope England
<u>10/14-6/15</u>
Holley Brandchaft-White

QuesGen Systems, Inc.
Creation and Maintenance of Data Tracking System for Program Evaluation

Trauma-Focused Therapy Provider Partners

Affiliated Team Members
Laurie Hanson, LCSW – Comer Mobile Unit

Trauma-Informed Care Initiative
Rachel Cane, MD
Meredithe McNamara, MD
Christopher Huff, A.M.

Partner Pilot Programs Began Summer 2015

Project FIRE
Pearl Dick
N'Kosi Barber
Ignition Community
Glass>ArtReach

Woodlawn Trauma Treatment Program
Sophia Duffy, PhD
Clinical Psych Grad Students from Wheaton College
1st Pres Church, Woodlawn

UChicago Dept. of Psychiatry
Sonya Dinizulu, PhD
Seeba Anam, MD

Tina Dorow, LCSW

La Rabida Children's Hospital Chicago Child Trauma Center

Key Messages for Trauma Recovery

1. It is not happening now.

   The trauma is over. It is in the past. You are here in the present.

2. You are safe.

   The adults here are responsible for your safety and you are worthy of care and protection.

3. You are not inherently dangerous/toxic.

   What is inside you (thoughts, feelings, dreams, impulses, etc.) cannot hurt you or others.

4. You are good.

   Whatever you have experienced and whatever you have had to do to survive, you are a good, strong person who can contribute to your community.

5. You have a future.

How You Can Help a Child Affected by Complex Trauma

Communicate an understanding that the child is not responsible for the violence and maltreatment.

Have a relationship that serves the child's needs instead of yours.

Have a relationship that is not solely about the child's experience of trauma.

See the whole child, not just what s/he has been through.

How You Can Help

Advocate for trauma-informed services.

Remain calm when confronted with horrifying information.

Be a historian for the child.

Facilitate information sharing across systems.

Communicate that the child is worthy of love, protection, and care.

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