The phenomenon of trauma: challenges and rewards of law enforcement-mental health partnerships

The Child Development-Community Policing Program

Steven Marans, PhD, MSW
Professor of Child Psychiatry and Professor of Psychiatry
Director, Childhood Violent Trauma Center
Eddie Levins
Deputy Chief (ret.) Charlotte-Mecklenburg Police Department
Sarah Greene, LCSW
Program Administrator of Trauma & Justice Partnerships
Mecklenburg County Health Department

Yale SCHOOL OF MEDICINE

Traumatic Situation

- **"...subject's estimation of his own strength compared to the magnitude of the danger and in his admission of helplessness if the danger is real and psychical helplessness if it is instinctual..."**

S. Freud

Sources of danger

- Loss of one's own life
- Loss of the life of a significant other
- Loss of love of another or of oneself
- Damage to the body
- Loss of control of impulses, affects and thoughts

Psychological trauma as injury

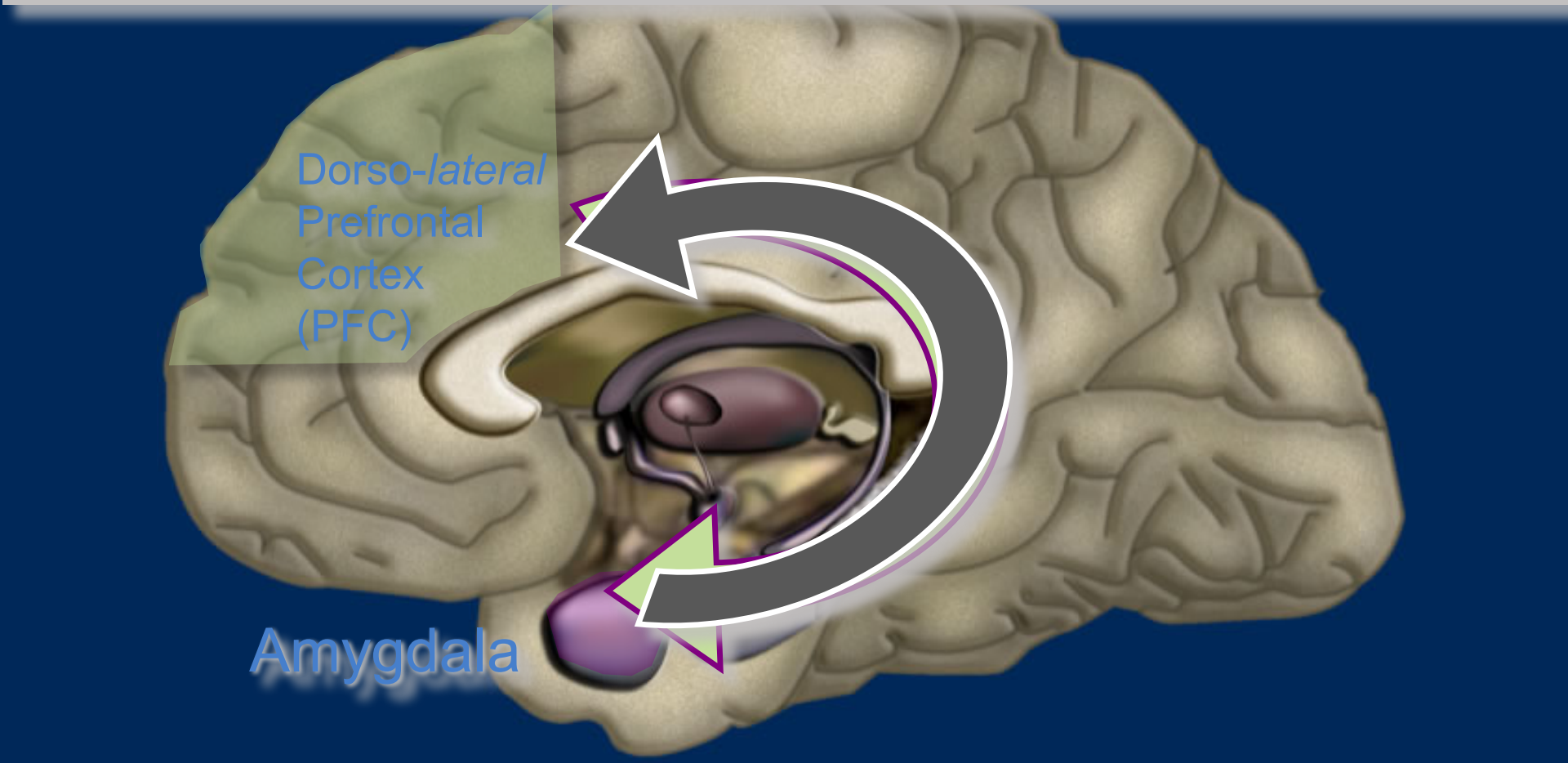
Overwhelming, unanticipated danger that leads to:

- **Subjective experience of helplessness, loss of control and terror**
- **Immobilization of usual methods for decreasing danger and anxiety (fight or flight)**
- **Neuro-physiological dysregulation that compromises affective, cognitive and behavioral responses to stimuli**

Mastery vs. Failure (Yun et al. Brain Imaging Behav 2010)

Mastery: Prefrontal Cortex "Control Center" suppresses activation of amygdala "Emotion Center"

Failure: Amygdala "Emotion Center" suppresses PFC Control Center and IMPAIRS SUBSEQUENT PFC activation (I.e., Helplessness)



Post-traumatic symptoms

Three major symptom areas:

- Re-experiencing
- Avoidance
- Hyper-arousal

Post-traumatic symptoms in children: Dysregulation and the search for control

Re-experiencing

- Traumatic reminders
- Intrusive memories
- Traumatic play and re-enactment
- Nightmares
- Flashbacks and dissociation
- Distressed when reminded
- Somatic complaints and discomfort

Post-traumatic symptoms in children: Dysregulation and the search for control

Avoidance:

- Actively avoids thinking or talking about event
- Avoids reminders of event (people, places, and things)
- Impaired recollection or memory
- New fears (e.g., separation, being alone, darkness, strangers)
- Sense of a foreshortened future or impending doom

Post-traumatic symptoms in children: Dysregulation and the search for control

Hyper-arousal:

- Nightmares or night terrors
- Difficulty falling or staying asleep
- Decreased attention or concentration
- Hyperactivity
- Irritability and changes in mood
- Increased aggression
- Hypervigilance and exaggerated startle response

Long-term Consequences to violence exposure

- **Without recognition, support and treatment early traumatic reactions to violence reactions can persist and result in long-term outcomes**

- **Can result in a variety of emotional, behavioral, social and psychiatric consequences**

- **<u>Examples of long-term sequelae</u>:**
  - **Attachment and relationship problems**
  - **PTSD**
  - **School failure**
  - **Suicidal behavior**
  - **Anxiety**
  - **Mood disorders**
  - **Substance abuse**
  - **Violent/ abusive behaviors**
  - **Somatic problems**
  - **Personality disorders**

Risk/Protective Factors

- ***Failure of recognizing/identifying post-traumatic distress by others***

- ***Absence of social/family support***

Clinical roadmap: Phases of Traumatic Reactions

- Immediate/acute reactions (from within moments to first 24-48 hours)
- Peritraumatic phase symptoms (up to 3 months after index event)
- Chronic PTSD and related disorders (3 months after index event)
- Delayed Onset (6 months after index event)

NatSCEV Highlights

3 in 5 children experienced at least one exposure to five types of violence in the past year

1 in 10 were injured in an assault

2 in 5 children were victims of at least one assault in the past year

1 in 20 children were sexually victimized in the past year

1 in 4 children witnessed a violent act in the past year

1 in 12 witnessed family violence in the past year

Finkelhor, D., Turner, H.A., Shattuck, A.M., and Hamby, S.L. 2013. *Violence, crime, and abuse exposure in a national sample of children and youth: An update.* JAMA Pediatrics 167(7):614–621.
U.S Department of Health and Human Services, 2012

Exposure to violence and consequences

- Estimated 15.5 million children exposed to domestic violence each year in US; 7 million exposed to severe and chronic violence (MacDonald, et.al., 2006)

- Children who have been exposed to domestic violence are 158% more likely to be victimized by violence themselves than counterparts from non-violent households—the risk was 115% higher for boys and 229% higher for girls (Mitchell and Finkelhor, 2001)

- Exposure to violence in early childhood is associated with higher risk for physical aggression, delinquency and violent behavior in adolescence (Jenkins & Bell, 1997; Thornberry, 1994; Shakoor & Chalmers, 1991; Carrion & Steiner, 2000)

Exposure to violence and consequences

- Adverse Childhood Experiences (ACE) study of 17,000 health care patients history of traumatic childhood events (physical abuse; interpersonal violence; sexual abuse; psychiatric disorder in caregiver; caregiver incarceration; absence of one or both parent(s); neglect) Felitti, et.al., 1998
- Exposure to 4 or more of these factors=4- to 12- fold increase in likelihood of alcoholism, drug abuse and suicide attempts
- Traumatic events are most significant predictors of ischemic heart disease; cancer; chronic lung disease; skeletal fractures and liver disease

Exposure to violence and consequences

- The long-term effects are evident in reports that nearly two thirds of people in drug treatment programs reported being abused as children (Swan, 1998)
- Sexual abuse has been reported by 62% of teenage mothers

Risk/Protective factors determining outcomes of exposure

- ***Failure to recognize a child's post-traumatic distress***
- ***Absence of social/family support***

Supra-clinical efforts

- **Clinic-based treatments alone often not capable of addressing magnitude of traumatic burdens**
- **Need for increased opportunities to identify affected children and families**
- **Need for increased awareness of childhood trauma in broader systems of care**
- **Need to identify collateral responses (e.g., re-establishing safety; provision of basic needs; return to routines; assessment and treatment of affected parents, etc.)**

The Challenge: Reaching and Intervening Early with Children and Families Impacted by PTE

- Children and families impacted by trauma were rarely identified or seen in mental health consulting rooms
- Non-mental health professionals who regularly respond to PTE's worked in isolation
- New approaches to acute and follow-up collaborative responses were needed
- New clinical strategies for decreasing post-traumatic suffering and development of longer-term disorders

Partnerships Between Police and Mental Health Professionals

- The Child Development-Community Policing Program (CDCP) began in New Haven in 1991 as response to tremendous increase in community violence
- Goals include increased contact and provision of services to families in the immediate aftermath of a potentially traumatic event (PTE)
- CDCP is a collaborative partnership between New Haven police, Yale Child Study Center clinicians, DCF and other social service agencies

Connecting the Dots:
CD-CP Program Elements

- Training for officers on the intersection of child development, human behavior, trauma and community policing
- Training for clinicians on police procedures, roles, responsibilities and tactics
- Acute response consultation service (24/7)
- Weekly multidisciplinary case conference
- Weekly clinical case conference

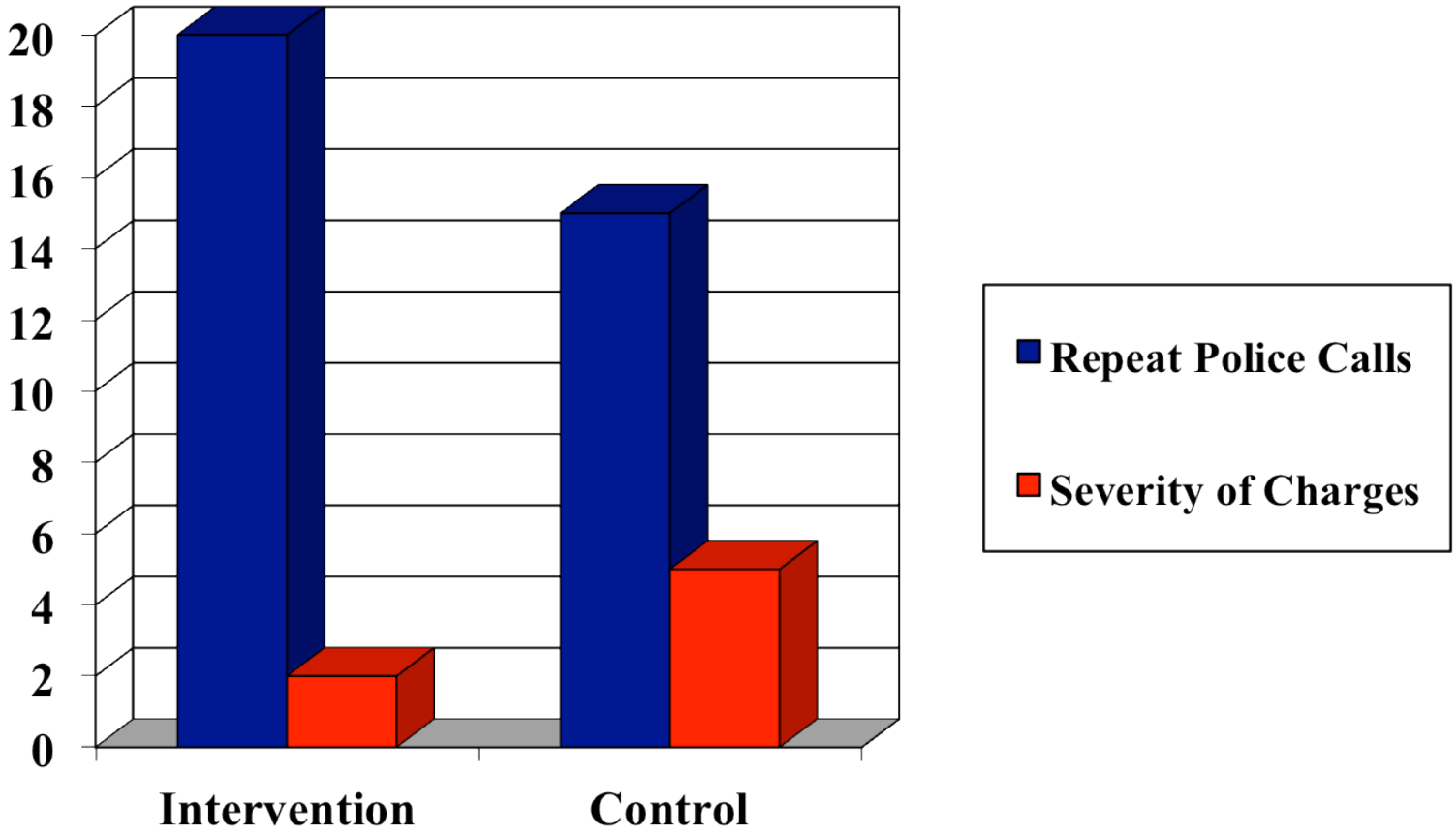
Goals of Acute Response

- Provide order and containment to situation
- Remove children from any further threat or source of trauma
- Make immediate plan for safety
- Coordinate with other professionals and service providers in identifying and responding to basic needs
- Assess and help to stabilize acute dysregulation
- Develop plan for follow-up clinical and extra-clinical interventions

Goals of CD-CP Collaborative Follow-up Visits

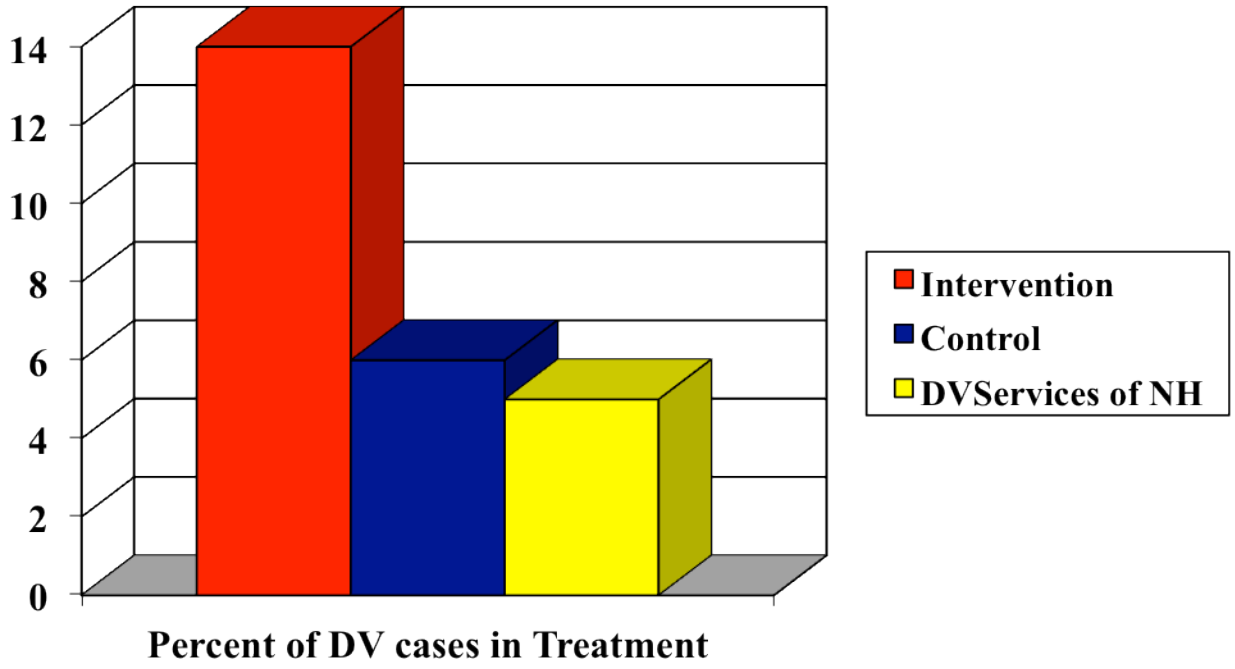
- Assess on-going threats to safety and order and develop plans to address those threats
- Improve victim's understanding and enforcement of court orders
- Increase access to information and concrete services
- Provide psychological screening and acute psychological support
- Increase access to treatment for child victims where needed

Outcome: Recidivism at 12 Months



Stover, C. S., Berkman, M., Desai, R., & Marans, S. (2010). The efficacy of a police-advocacy intervention for victims of domestic violence: 12 month follow-up data. *Violence Against Women, 16(4), 410-425.*

Outcome: Percentages Entering Treatment



Stover, C. S., Berkman, M., Desai, R., & Marans, S. (2010). The efficacy of a police-advocacy intervention for victims of domestic violence: 12 month follow-up data. *Violence Against Women, 16(4), 410-425.*

Video: Connecting Cops and Clinicians

http://www.nccev.org/programs/cdcp.aspx#4-173834

CVTC responses

Over past 24 years the Yale Trauma Section team has responded to approximately 20,000 children and their families who have been exposed to:

- **Murders, murder/suicides**
- **Non-lethal domestic violence**
- **Sexual abuse/assault**
- **Physical abuse and neglect**
- **Suicides and drug overdose**
- **Kidnapping**
- **Hostage and barricade situations**
- **Serious motor vehicle accidents**
- **Fires**

From Model Development to Consultation and Dissemination

- CDCP replication and adaptation
- Current collaboration with IACP and DOJ developing training and resources for police response to children exposed to violence nationally