Trauma-informed Care: Attachment, Regulation, and Competence (ARC) Model

Delphine Collin-Vézina, PhD

Director, Centre for Research on Children and Families
Chair, Nicolas Steinmetz and Gilles Julien Chair in Social Pediatrics in Community
Chair, Tier II Canada Research Chair in Child Welfare
Associate Professor, School of Social Work & Associate Member, Department of Pediatrics
McGill University
Objectives:

- To distinguish simple trauma from complex trauma
- To understand the biological, psychological and relational impact of complex trauma
- To document the principles of trauma-informed care
- To learn about trauma-informed initiatives based on the *Attachment, Regulation, and Competency* model

Until we understand that traumatic symptoms are physiological as well as psychological, we will be woefully inadequate in our attempts to help (victims) heal.

- Dr. Peter Levine, Author of *Waking the Tiger* and *Healing Trauma*
Adverse Childhood Experiences (ACE)

- Household dysfunction:
  - Parental substance abuse
  - Parental separation/divorce
  - Parental mental illness
  - Conjugal violence
  - Parental incarceration

- Abuse:
  - Psychological
  - Physical
  - Sexual

- Neglect:
  - Emotional
  - Physical

Additional victimization and adversity items proposed to be added:
- Peer victimization
- Peer isolation/rejection
- Community violence exposure
- Low socioeconomic status (SES)

Finkelhor et al. (2015)

https://aces too high.com
Adverse Childhood Experiences (ACE)

ACEs Conceptual Framework

- Early Death
- Disease, Disability & Social problems
- Health-Risk Behaviours
- Social, Emotional, Cognitive Impairments
- Disrupted/Altered Neurodevelopment
- Adverse Childhood Experiences
Impact of Multiple ACEs

Multiple traumas — Cumulative Effect

The ACE Effect:
Cumulative ACES increase risk for poor outcomes

Dose-response is a direct measure of cause & effect

The “response” — in this case the occurrence of the health condition — is caused directly by the size of the “dose” — in this case, the number of ACES. Four or more ACES increases the risk of poor outcomes at a higher rate.

Impact of Multiple ACEs: Unidentified Trauma

An Iceberg Phenomenon

Diagnoses and observable behaviours

Meaning behind trauma-related behaviours
In the absence of a trauma-informed lens, the client’s presenting problems can be:

- Misdiagnosed
- Labelled in pathologizing and harmful ways

A trauma-informed approach recognises:

1. The important prevalence of traumatic life experiences among vulnerable populations.
2. How challenging it can be to establish a therapeutic alliance with these clients.

Harris & Fallot, 2001
Poole & Greaves, 2010
On Becoming Trauma Informed

“I’m right there in the room, and no one even acknowledges me.”
Study on Youth in Residential Care

**Gender**
- Female: 45
- Male: 55

**N = 53**

**Age**
- 14: 26.4
- 15: 22.6
- 16: 30.2
- 17: 20.8

**Racial Group**
- Aboriginal or 1st Nations: 20.8
- Black: 18.9
- White or European: 39.6
- Other: 17

Collin-Vézina et al., 2011
# Study on Youth in Residential Care

## Childhood Trauma Questionnaire

<table>
<thead>
<tr>
<th>Type of Abuse</th>
<th>None or minimal</th>
<th>Low to moderate</th>
<th>Moderate to severe</th>
<th>Severe to extreme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse</td>
<td>38%</td>
<td>19%</td>
<td>9%</td>
<td>34%</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>32%</td>
<td>26%</td>
<td>9%</td>
<td>32%</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>62% (none)</td>
<td>6%</td>
<td>9%</td>
<td>23%</td>
</tr>
<tr>
<td>Physical neglect</td>
<td>45%</td>
<td>15%</td>
<td>15%</td>
<td>25%</td>
</tr>
<tr>
<td>Emotional neglect</td>
<td>41.5%</td>
<td>24.5%</td>
<td>17%</td>
<td>17%</td>
</tr>
</tbody>
</table>
Compounded maltreatment:

• **83%** of the sample reported **at least one form** of maltreatment.

• **76%** of the youth reported **MULTIPLE (2 or MORE) forms** of maltreatment.

• **64%** of the youth reported **3 or MORE** forms of maltreatment.

• **40%** of the youth reported **4 or MORE** forms of maltreatment.

• **19%** of the sample experienced **ALL 5 TYPES** of child maltreatment.
Study on Youth in Residential Care

However, the reasons these 53 youth were taken into child protection care (3 sub-sections) were poorly reflective of the traumas experienced:

- 83.0% behaviour problems
- 26.4% neglect
- 5.7% sexual abuse,
- 5.7% abandonment
- < 5% emotional abuse
- < 5% physical abuse

Milne & Collin-Vézina, 2014
Milne, 2011
Adolescent male who is...

Aggressive to people
Deceitful
Not receptive to feedback
Easily frustrated
Belittling
Quick to anger

OR...

A young person who is suffering
Complex trauma results from experiences which:

1. Are **interpersonal** and often involve betrayal;
2. Are **repeated or prolonged**;
3. Involve **direct harm** via different forms of abuse (psychological/emotional, physical, sexual), neglect, or abandonment by caregivers or other adults responsible for the child’s care, protection or upbringing;
4. Occur during **vulnerable developmental periods**, such as early childhood, or which significantly disrupt already acquired developmental competencies at any point.

Ford & Courtois, 2013
Complex trauma sequelae are grouped into 7 main domains:

- Biology
- Attachment
- Affect Regulation
- Dissociation
- Behaviour Management
- Cognition
- Identity & Self Concept
When faced with a potential danger, our brain and body act together to keep us alive:
- The danger response (fight, flight or freeze) is activated.

Chronic exposure to danger or exposure to extreme danger can lead to and over-active alarm system.

“Whether the trauma is physical, psychological or sexual it sets off a ripple of hormonal changes that organize the brain to cope in a hostile world”\(^1\)

\(^1\)Wilkinson, 2003
Neurobiology of trauma = neurobiology of fear

What happens to the brain when terrifying events are being experienced? Some dramatic changes (cascade effects)

- The critical brain structures in the fear system starts firing: amygdala/HPA axis are activated; stress hormones are released; high-level cognitive capacities are shut down.

- Hormones interfere with functioning of hippocampus and sensory thalamus: memory processes are impaired (fragmented, overly imprinted physical memories); affect regulation is compromised.
Other potential changes in the brain function:

- The threat perception system is enhanced
  - Danger is perceived in non-threatening situations
- The filtering system is unable to perform its function correctly
  - Ability to distinguish between important and unimportant input is diminish
- The self-sensing brain is dampened
  - Sense of consciousness stays in a rudimentary stage
- The verbal regions are off (observed in EEG)
  - Reduced capacity to rely on verbal abilities to communicate to others and to oneself (‘inner voice’)

Dr. Bessel van der Kolk
Introducing the Brain House: The Upstairs and the Downstairs

‘The upstairs characters are thinkers, problem solvers, planners, emotion regulators, creatives, flexible and empathic types. (...) The downstairs folk are the feelers, they look out for danger, sound the alarm and make sure we are ready to fight, run or hide when we are faced with a threat.’

Dr. Hazel Harrison, inspired by Dr. David Siegel: http://www.mindful.org/how-to-teach-your-kids-about-the-brain/
‘Our brains work best when the upstairs and the downstairs work together. Imagine that the stairs connecting upstairs and downstairs are very busy with characters carrying messages up and down to each other.’

In face of adversity, ‘the downstairs brain flips the lid on the upstairs brain. (...) the stairs that normally allow the upstairs and downstairs to work together are no longer connected’
Trauma is experienced in the context of a lack of a ‘secure base’ to explore the world confidently and to develop a sense of purpose in relationship.

Trauma-impacted children may:
• Perceive the world as a dangerous place and expect to be hurt in relationships; be detached, unresponsive or resistant to comforting (Avoidant)
• Lack confidence in themselves to succeed in the social world; be overly dependent on others; show indiscriminate sociability (Anxious)
• Act in ways that do not make sense, demonstrating unpredictable, confusing or erratic behavior in relationships (Disorganized)

Related Dx: Reactive Attachment Disorder; Disinhibited social engagement disorder
The ability to identify, express and modulate emotions in continuity with cognitive and perceptual experiences.

Trauma-impacted children may:
- Have a limited vocabulary for identifying emotions (e.g., feeling “bad”)
- Be disconnected from his/her emotional experiences
- Not have developed adaptive strategies for expressing and modulating difficult or intense emotions.

Related Dx: Mood Disorders (e.g. Disruptive Mood Dysregulation Disorder)
A process by which thoughts, memories, emotions and identity are not integrated into a coherent sense of self (fragmentation). This is thought to be a protective strategy developed to help children cope with trauma experiences.

Trauma-impacted children may:
- Use dissociation to escape situation that overwhelm their coping capacities
- Take refuge in their heads when fight or flight are not options

Related Dx: Dissociation Disorders (identity, amnesia, depersonalization)
The ability to remain in control of one’s behaviour in a way that is adaptive to diverse situations.

Trauma-impacted children may:
- Have too much or too little control (externalizing vs. inhibition)
- Engage in behaviours (e.g. self-harm) in order to regain control when faced with traumatic experiences and the emotions they elicit

Related Dx: Conduct Disorder, ODD (Substance abuse? Eating disorders? Non-Suicidal Injury Disorder?)
The acquisition of the necessary reasoning abilities for optimal development, notably executive functioning, in keeping with the child’s developmental stage.

Trauma-impacted children may present with:
- Delays in cognitive and language abilities
- Difficulties in problem resolution
- School delays, failures and drop outs

Related Dx: Misdiagnosed ADHD?
The way in which a person perceives and considers him/herself, influencing the way in which they present themselves. Self-concept is created in our relationships with others: across our experiences and the way others view us.

Trauma-impacted youth may:
• Have negative views of themselves or exaggerated sense of self-importance
• Attribute failures to themselves (internal locus of control) or blame others indiscriminately
• Expect or even elicit rejection (because they perceive themselves as not loveable)
Effective Psychotherapies: Complex Trauma

Complex Trauma Psychotherapy options:

- Trauma Adaptive Recovery Group Education and Therapy (TARGET; Ford, Russo)
- Integrative Treatment for Complex Trauma in Adolescents (ITCT-A; Lanktree, Briere)
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS; DeRosa, Pelcovitz)
- Trauma Focused-CBT (TF-CBT; Cohen, Deblinger, Mannarino)
Principles of Trauma-Informed System

1. Maximize Physical and Psychological Safety for Children and Families
2. Partner with Agencies and Systems that Interact with Children and Families
3. Identify Trauma-Related Needs of Children and Families
4. Enhance Child Well-Being and Resilience
5. Enhance the Well-Being and Resilience of Those Working in the System
6. Enhance Family Well-Being and Resilience

NCTSN Child Welfare Committee, 2012
ARC: A System-Based Approach to Trauma

Of the handful of trauma-informed interventions, to our knowledge, only one presents a multi-systemic design that allows for implementation among direct-care staff.

Targets the 3 core resiliency domains: Attachment, Self Regulation, and Competency
ARC: A System-Based Approach to Trauma

Child Caregivers System

Attachment
- Routines & Rituals
- Caregiver Affect Management
- Attunement
- Consistent Response

Self-Regulation
- Identification
- Modulation
- Expression

Competency
- Executive Functioning
- Identity
- Trauma Integration
Research – Current Implementation in Quebec
ARC Programs

• Foster parents
  – Objective: promote placement stability
  – Format: 12 weekly 2.5 hour meetings on the 10 ARC blocs

• Residential care staff
  – Units that serve children aged 3 to 17 under the child protection act and units that serve youth aged 12 to 17 under the young offenders act
  – Objective: reduce use of restraints and develop trauma-informed professional practices (beliefs, attitudes, behaviours)
  – Format: 2-day training and monthly clinical consultation/integration meetings
  – Regional and provincial practice communities
Many children and youth experience adverse life events and these traumatic experiences too often go undetected.

Their (mis)behaviors can be misunderstood and inadequately addressed.

Recognition of the benefits to trauma-informed approaches is expanding, along with interest in extending delivery within child-serving systems.

A whole-person, multi-tiered approach providing support at the child, caregiver/personnel and system levels can help mitigate the effects of trauma and chronic stress.
All questions can be addressed to Delphine Collin-Vézina: delphine.collin-vézina@mcgill.ca