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Where I'm coming from...

- Teacher / counselor
- Mental health clinician in juvenile corrections
- Moved to social psychology -- researched conditions of healing/helping and resiliency during doctoral program
- Began work on trauma/adversity and courts about 15 years ago



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- Led NCJFCJ trauma consultation for courts project and the first national summit on trauma and the courts
- Now working on universal trauma-responsive interventions that emphasize environment and connectedness (e.g., courthouse dogs)
- Courts are part of the healing community

DEI *clap* IS *clap* **CRITICAL** *clap*

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Who are you...?

Please type your occupation in the chat box.



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Learning Objectives

- Upon completion of this session, participants will be able to...
 - Describe the role of the court in a healing community;
 - Discuss the history of the conceptualization of trauma through today;
 - List three promising innovations in coordinated systems of care to address victimization, trauma, etc.; and
 - Provide three goals for the future of trauma-responsive justice.

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Assumptions

- Participants understand that...
 - flight, fight, freeze, and flock behaviors are normative responses to existential danger;
 - the “4Fs” are problematic when they become the automatic response when one perceives threat (yet, no real threat exists);
 - repeated experiences shape behavior – i.e., “what gets fired gets wired”; and
 - life is tough, and it is even tougher for some more than others *even without trauma* – i.e., life is not a level playing field.

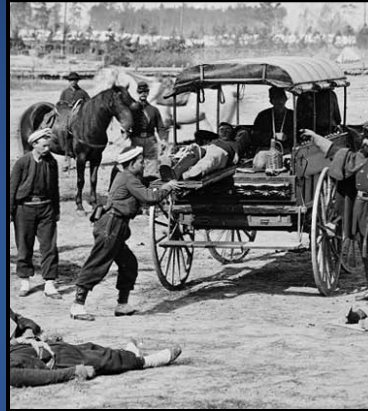
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800 BC – 1900 AD

- Trauma's impact on the human condition has been written about since ancient times (e.g., Homer).
- "Nostalgia" (≈ 1760's): soldiers describing missing home, feeling sad, sleep problems, and anxiety. This description of PTSD-like symptoms was a model of psychological injury that existed into the Civil War.
- "Soldier's heart" or "irritable heart" (≈ 1860's / Civil War) was marked by a model of physical injury with symptoms of rapid pulse, anxiety, and trouble breathing. Described as overstimulation of the heart's nervous system, soldiers were often returned to battle after receiving drugs to control symptoms.
- "Railway spine" (≈ 1860's / Europe) descriptions of the psychological impact of railroad accidents also added to early understanding of trauma-related conditions. Injured passengers reported sleeping problems and anxiety, and those who died had autopsies that suggested injury to the central nervous system.



Source: History of PTSD in Veterans: Civil War to DSM-5 by Matthew J. Friedman, MD, PhD

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World War I



- "Shell shock" or "war neuroses" (≈ 1915) was first thought to be the result of hidden damage to the brain caused by the explosion of artillery shells, but changed when more soldiers who had not been near explosions had similar symptoms. Soldiers often received only a few days of rest before returning to the war zone. For those with severe or chronic symptoms, treatments focused on daily activity to increase functioning. In European hospitals, "hydrotherapy" (water) or "electrotherapy" (shock) were used along with hypnosis.

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World War II

- Combat Stress Reaction (CSR) or "battle fatigue" (~ 1940) is thought to be responsible to up to half of military discharges at that time. CSR was treated using "PIE" (Proximity, Immediacy, Expectancy) principles requiring treating casualties without delay (e.g., rest) and making sure sufferers expected complete recovery.



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PTSD and the DSM



- In 1952, the American Psychiatric Association (APA) produced the first Diagnostic and Statistical Manual of Mental Disorders (DSM-I), which included "gross stress reaction."
- This diagnosis was eliminated in the second edition of DSM (1968), and instead included "adjustment reaction to adult life." This diagnosis was limited to three examples of trauma: unwanted pregnancy with suicidal thoughts, fear linked to military combat, and anxiety/confusion in prisoners who face a death sentence.
- In 1980, APA added PTSD to DSM-III, which stemmed from research involving returning Vietnam War Veterans, Holocaust survivors, sexual trauma victims, and others. Links between the trauma of war and post-military civilian life were established.
- The DSM-III criteria for PTSD were revised in DSM-III-R (1987), DSM-IV (1994), DSM-IV-TR (2000), and DSM-5 (2013) to reflect continuing research.

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PTSD Today

- Progress!
- An important change in DSM-5, is that PTSD is no longer an Anxiety Disorder. PTSD is sometimes associated with other mood states (for example, depression) and with angry or reckless behavior rather than anxiety. So, PTSD is now in a new category, Trauma- and Stressor-Related Disorders.
- PTSD includes four different types of symptoms: reliving the traumatic event (also called re-experiencing or intrusion); avoiding situations that are reminders of the event; negative changes in beliefs and feelings; and feeling keyed up (also called hyperarousal or over-reactive to situations). Most people experience some of these symptoms after a traumatic event, so PTSD is not diagnosed unless all four types of symptoms last for at least a month and cause significant distress or problems with day-to-day functioning.
- Concern/narrative around use of "disorder".
- More public, less stigma, and not just military/veterans.



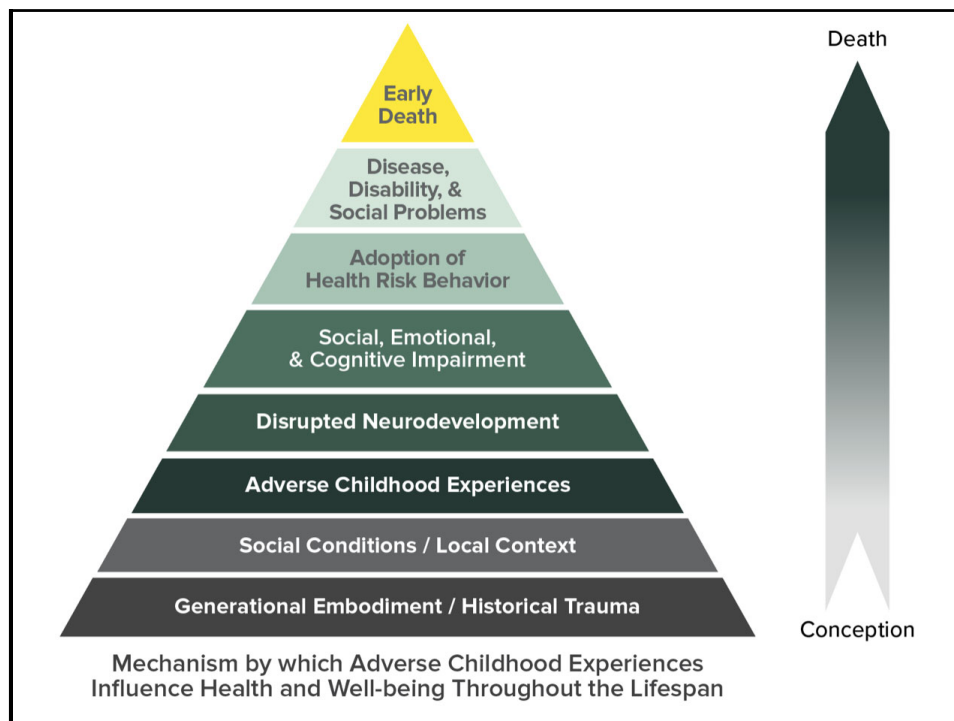
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Awareness

- **Jacqueline Kennedy Onassis** was the first lady to President John F. Kennedy when she experienced the assassination of her husband firsthand.
- **Darrell Hammond** (Saturday Night Live comedian and impressionist) has spoken publicly about his diagnosis of PTSD stemming from severe abuse as a child, and has dealt with years of alcohol/drug abuse as well as self-harming.
- **Mick Jagger** is said to have developed PTSD after his girlfriend died by suicide in their home.
- **Whoopi Goldberg** was diagnosed with PTSD from witnessing two planes collide in midair as a child, and has dealt with severe panic attacks when boarding planes.

Not only more awareness of trauma, but also understanding of adversity and toxic stress ...

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REFRESHER: In general, adversity and trauma can lead to a robust fight, flight, freeze, or flock response in the face of *perceived* danger...

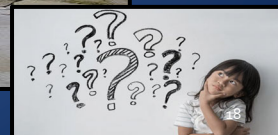


Consider this about traumatic stress reactions:

1. What gets fired gets wired;
2. Normal (and desirable) in face of danger – they are just out of place when no danger is present; and
3. Could these types of trauma reactions also exist at family and system levels?

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Development: Missing Stairs



“Treatment”: Community vs. Clinical

- Safety, self-determination, and support [S.S.S.] across persons, practice, policy, and environment [P.P.P.E.]
 - Universal precautions approach (e.g., sense of safety) is good for both consumers and administrators of justice/health/etc.
- Trusting relationship with therapist; learn and practice coping / self-soothing skills; revisit traumatic event(s) or triggers and practice coping / self-soothing skills (guided and individually); reframe narrative from “survive to thrive”; provide support and nurture pro-social connection(s).

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Poll

About how many scientific articles were published on “trauma-informed systems of care” in the last 12 months?

- A. 75
- B. 250
- C. 3500
- D. 9000
- E. 13000
- F. 25000 +

Slightly over 13,000 peer reviewed scholarly/academic publications in last 12 months alone including contexts of schools, medicine/dentistry, child welfare, juvenile justice, courts, prisons, etc.

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We know some other things, too...


- Trauma-informed care is a robust model based on science.
- Victims can be offenders / offenders can be victims: "injury" model much more helpful.
- Trauma and adversity is a universal rallying point for systems and communities: everyone knows what "hurt" feels like.
- Good trauma-informed care is a win-win for both consumers and administrators regardless of presenting issue(s).
- Data indicates trauma-informed care saves money and is more humane (e.g., less sick leave, helps with secondary stress, etc.).
- LSC / coordination, SAMHSA, NCJFCJ, NCTSN, growth in living/learning/social labs.

Good stuff! *clap* Progress! *clap* Celebrate! *clap*

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Part III

The Future

NEXT EXIT 

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Race. Justice. Health.

- Diversity, equity, and inclusion [DEI] is a priority.
- If powerful institutions do not “look like” or otherwise resonate with or reflect the community it serves, the community will fundamentally not feel safe in the face of that power.
- Safety is a core component of healing from trauma/adversity and victimization.
- DEI is a trauma-responsive practice.

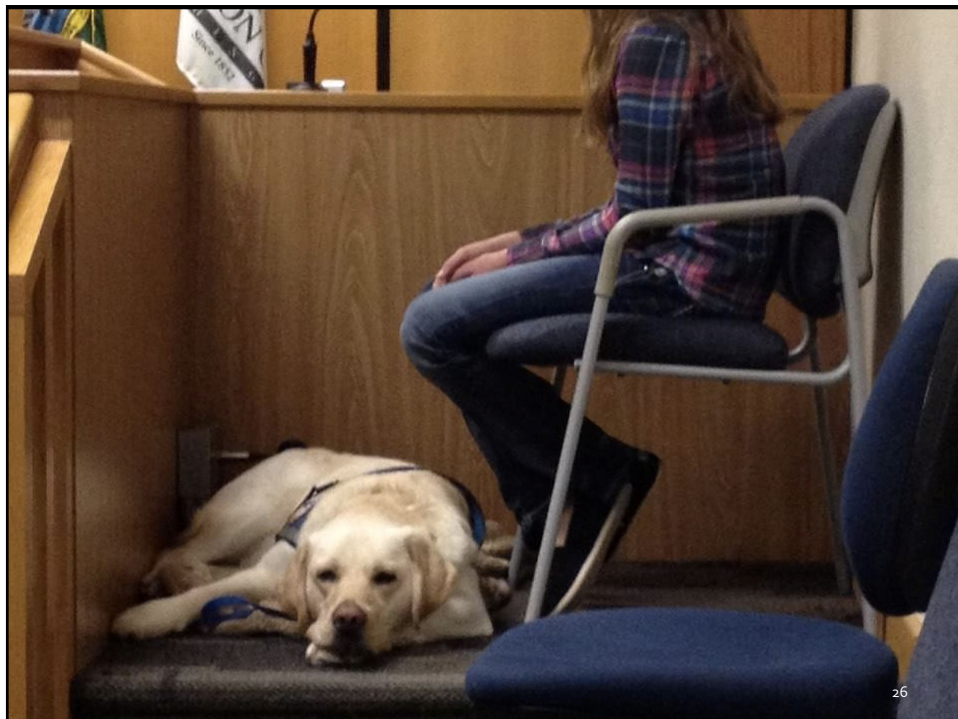
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Communities of Healing

- Public health is an issue of justice (e.g., see COVID).
- Courts are part of the community of healing.
- Reciprocal communication, coordination, and collaboration are critical to success.
- Perhaps the *OneHealth* model is a promising guide post-pandemic (i.e., interdisciplinary, integrated, and holistic approach to global health that considers humans, animals, climate/environment, race/culture, indigenous practices, etc. and their interdependence).

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Speaking of Animals...



Environment Matters

ACTUAL COURT

- [THEN / 2015] A courthouse with dark, paneled courtrooms, staid corridors lined with headshots of past judges, and closed windows with shades drawn. Families waited in an overcrowded, chaotic main hall, craning to hear each time the bailiff appeared and shouted the case name at the top of his lungs. For a court whose job was to rehabilitate and strengthen children and families, the environment was hardly conducive.
- [NOW] Classical music plays on the piano in the lobby. Doors are painted the colors of the rainbow, and a Dr. Seuss mural consumes a wall on the way to the child abuse department. Staff smile and show families where to wait. Signs indicate when and where cases will be heard. Attorneys quietly escort clients to assigned courtrooms when cases are called.

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More focus on environment and “easy” wins



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Patience

- Trauma and adversity are, unfortunately, part of being human.
- Issues did not just appear overnight (e.g., racial inequality, institution versus consumer focus, traumatization, healthcare, poverty, etc.).
- There is not “social ills vaccine” (yet) – it will take time and effort.
- Need to balance quick solutions with long term reality (i.e., think both proximal and distal objectives).
- Injury by 1000 cuts requires healing by 1000 band aids – every single contact is a point of potential healing.

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Connectedness

- We are social animals; connection is critical for healing (e.g., 30% of change).
- At the end of the day, customer service is our job; it is what we signed up for and should feel privileged to have the opportunity to help others in need.
- Social allergies won't kill you (but secondary stress might).
- Warm touch and warm handoffs; people helping people.
- Consumer advocates, health/system navigators, liaisons, care specialists, etc. as a specialty and career (with commensurate status and pay – it is a skill!).
- Empathy. Universal precautions. Environment. Transparency.

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Will we have the



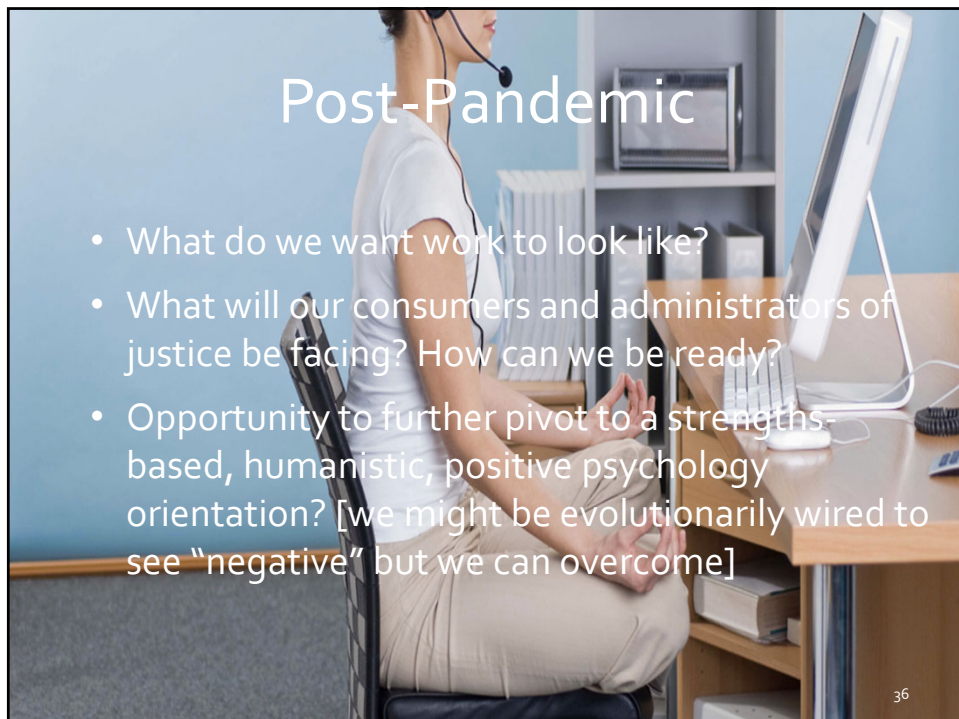
- ... (e.g., court clinics).
- Technology (i.e., artificial intelligence, machine learning, quantum computing, robotics, etc.).
- Improved data storage, sharing, and security (e.g., improved servers, cloud computing, client level storage, broadband/optical transmission, etc.).
- Resource sharing and efficiencies.
- Improved transportation systems and driverless transportation.
- Virtual options (i.e., can it be done online).
- Technology will promote rapid cycle testing/CD in order for complex systems to stay on their toes and respond to real time.

A photograph of the Mars helicopter, Ingenuity, on the surface of Mars. The helicopter is a small, four-rotor craft with a solar panel on its back, standing on a sandy, reddish-brown terrain under a hazy, orange sky. The background shows distant, low mountains.

Even More Technology?

- The promise of epigenetic research.
- Neuroscience – mapping / imaging.
- Vaccine “moon shot” shows us what we can do when focused.
- Medication advances (MDMA, etc.).
- We are flying helicopters remotely on Mars; can we really not figure out a way to be more humane in our day-to-day work and make life a bit easier for everyone?

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A photograph of a woman sitting in a chair at a desk, meditating. She is wearing a white t-shirt and beige pants, with her hands resting on her knees in a mudra. She is wearing a headset with a microphone. In front of her is a large computer monitor. The background shows a modern office setting with shelves and a blue wall.

Post-Pandemic

- What do we want work to look like?
- What will our consumers and administrators of justice be facing? How can we be ready?
- Opportunity to further pivot to a strengths-based, humanistic, positive psychology orientation? [we might be evolutionarily wired to see “negative” but we can overcome]

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Where do you think we'll be in 25 years?



Questions?



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Thank you!

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